

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155323	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2015
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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 22, 23, 24, 25, 26, and 29, 2015</p> <p>Facility number: 000216 Provider number: 155323 AIM number: 100267580</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census payor type: Medicare: 3 Medicaid: 32 Other: 5 Total: 40</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning</p>			

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

TITLE

(X6) DATE

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

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	<p>abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview, the facility failed to thoroughly investigate an injury of unknown source and report an allegation of abuse immediately to the Administrator of the facility for 1 of 1 residents reviewed for abuse and 1 of 3 abuse allegations</p>	F 0225	I. Both incidents have been thoroughly investigated and reported to ISDH. The Administrator and DON were re-educated as to inadequate documentation reflective of investigation conducted relative to Resident #7. The involved housekeeper was re-educated as	07/29/2015

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	<p>reviewed. (Resident #7 and Resident #9)</p> <p>Findings include:</p> <p>1. Interview with the Director of Nursing (DON) on 6/23/15 at 2:36 p.m. indicated Resident #7 had experienced a fracture in the last 30 days. She further indicated the resident had fractured her right femur and it was not related to a fall.</p> <p>On 6/24/15 at 11:55 a.m. Resident #7 was observed in the Main Dining Room seated in a Geri chair (a reclining chair with wheels). Her right leg was elevated on two pillows with her right heel floated; she had an immobilizer in place to her right leg and a podus boot (a soft boot used to prevent pressure on the heel) on her right foot.</p> <p>The record for Resident #7 was reviewed on 6/24/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and osteoarthritis.</p> <p>The 5/13/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired, was totally dependent with transfers and required assist of 2 or more staff for transfers.</p>		<p>to the necessity of reporting any allegation of abuse involving Resident #9 and any other resident to the Administrator immediately. II. Review of all incidents/allegations within the last 30 days will be reviewed in an effort to confirm thorough, documented investigation conducted and confirm immediate reporting to the Administrator of any allegation of abuse. Should a concern be identified, the same shall be addressed. III. As a means to ensure ongoing compliance, the facility Administrator and DON have been re-educated as to the conducting and documenting of a thorough investigation. Staff have again been re-educated as to the facility policy of immediate reporting of any allegation of abuse IV. As a means of quality assurance, the Administrator shall be responsible to confirm with the Regional Director thorough, documented investigation of any investigation, including review of immediate reporting of any allegation to the Administrator. Should concerns be identified, immediate re-education and/or corrective action shall be implemented, as warranted. A summary of the investigations conducted and any concerns/corrective actions taken shall be reported to the Quality Assurance Committee during quarterly meetings ongoing.</p>		

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	<p>A Nurse's Noted, dated 5/14/15 at 12:00 p.m., indicated the resident was having pain to the right upper thigh with movement and a bruise was noted below the right knee. The Physician was notified and orders were received.</p> <p>A Physician's Order, dated 5/14/15, indicated an order for an x-ray of the right hip, x-ray of the right femur, and an x-ray of the right knee.</p> <p>X-ray results for the right hip, right femur, and right knee, dated 5/14/15, indicated a "...supracondylar fracture distal femur of indeterminate age..."</p> <p>A Nurse's Note, dated 5/15/15 at 12:40 a.m., indicated the X-ray results were received late on 5/14/15 and the Nurse Practitioner was notified. New orders were received to send the resident to the emergency room for treatment of the fractured femur. The Nurse's Note further indicated the DON and Administrator were notified.</p> <p>Review of an incident investigation, dated 5/15/15, indicated an investigation was started. The preventative measures taken indicated "...the investigation continues, however, at this point there are no indicators that this resident has had any recent event that may have caused</p>			

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	<p>this injury. There are also no indicators that this occurred as a result of an act by another person..."</p> <p>The investigation included two written statements, one from DON and one from the Minimum Data Set (MDS) Nurse. The investigation lacked documentation to indicate any other staff had been interviewed.</p> <p>Interview with the Administrator 6/25/15 at 2:13 p.m. indicated the nurse and CNA working with the resident at the time of the fracture had been interviewed but no statements were taken or written.</p> <p>Interview with the Regional Director on 6/25/15 at 3:20 p.m. indicated he understood the investigation of the fracture was not considered thorough.</p> <p>Interview with the Administrator on 6/29/15 at 4:27 p.m. indicated all injuries of unknown origin should be investigated as alleged occurrences of abuse per policy.</p> <p>2. The record for Resident #9 was reviewed on 6/29/15 at 4:10 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and depression</p>			

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F 0226 SS=D Bldg. 00	<p>Review of Quarterly MDS Assessment dated 2/21/15, indicated the resident was cognitively impaired.</p> <p>Review of a incident investigation, dated 6/17/15, indicated on the afternoon of 6/16/15 Housekeeping #1 told CNA #2 that on 6/15/15 she thought CNA #1 was a little rough with Resident #9 during a transfer. CNA #2 reported the alleged abuse to the DON, who then reported it to the Administrator. The investigation indicated Housekeeping #1 received disciplinary action due to her failure to report abuse timely per facility policy.</p> <p>Interview with the Administrator on 6/29/15 at 4:27 p.m. indicated Housekeeping #1 should have reported the allegation of abuse to her immediately.</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview,</p>	F 0226	I. Both incidents have been	07/29/2015			

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	<p>the facility failed to follow the facility's abuse policy, related to thoroughly investigating an injury of unknown source and reporting an allegation of abuse to the Administrator immediately 1 of 1 residents reviewed for abuse and 1 of 3 abuse allegations reviewed. (Resident #7 and Resident #9)</p> <p>Findings include:</p> <p>1. Interview with the Director of Nursing (DON) on 6/23/15 at 2:36 p.m. indicated Resident #7 had experienced a fracture in the last 30 days. She further indicated the resident had fractured her right femur and it was not related to a fall.</p> <p>The record for Resident #7 was reviewed on 6/24/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and osteoarthritis.</p> <p>The 5/13/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired, was totally dependent with transfers and required assist of 2 or more staff for transfers.</p> <p>A Nurse's Noted, dated 5/14/15 at 12:00 p.m., indicated the resident was having pain to the right upper thigh with</p>		<p>thoroughly investigated and reported to ISDH. The Administrator and DON were re-educated as to inadequate documentation reflective of investigation conducted relative to Resident #7. The involved housekeeper was re-educated as to the necessity of reporting any allegation of abuse involving Resident #9 and any other resident to the Administrator immediately. II. Review of all incidents/allegations within the last 30 days will be reviewed in an effort to confirm thorough, documented investigation conducted and confirm immediate reporting to the Administrator of any allegation of abuse. Should a concern be identified, the same shall be addressed. III. As a means to ensure ongoing compliance, the facility Administrator and DON have been re-educated as to the conducting and documenting of a thorough investigation. Staff have again been re-educated as to the facility policy of immediate reporting of any allegation of abuse IV. As a means of quality assurance, the Administrator shall be responsible to confirm with the Regional Director thorough, documented investigation of any investigation, including review of immediate reporting of any allegation to the Administrator. Should concerns be identified, immediate re-education and/or corrective</p>		

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	<p>movement and a bruise was noted below the right knee. The Physician was notified and orders were received.</p> <p>A Physician's Order, dated 5/14/15, indicated an order for an x-ray of the right hip, x-ray of the right femur, and an x-ray of the right knee.</p> <p>A Nurse's Note, dated 5/15/15 at 12:40 a.m., indicated the X-ray results were received late on 5/14/15 and the Nurse Practitioner was notified. New orders were received to send the resident to the emergency room for treatment of the fractured femur. The Nurse's Note further indicated the DON and Administrator were notified.</p> <p>Review of an incident investigation, dated 5/15/15, indicated an investigation was started. The preventative measures taken indicated "...the investigation continues, however, at this point there are no indicators that this resident has had any recent event that may have caused this injury. There are also no indicators that this occurred as a result of an act by another person..."</p> <p>The investigation included two written statements, one from DON and one from the Minimum Data Set (MDS) Nurse. The investigation lacked documentation</p>		<p>action shall be implemented, as warranted. A summary of the investigations conducted and any concerns/corrective actions taken shall be reported to the Quality Assurance Committee during quarterly meetings ongoing.</p>				

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	<p>to indicate any other staff had been interviewed.</p> <p>Interview with the Administrator 6/25/15 at 2:13 p.m. indicated the nurse and CNA working with the resident at the time of the fracture had been interviewed but no statements were taken or written.</p> <p>Interview with the Regional Director on 6/25/15 at 3:20 p.m. indicated he understood the investigation of the fracture was not considered thorough.</p> <p>Interview with the Administrator on 6/29/15 at 4:27 p.m. indicated all injuries of unknown origin should be investigated as alleged occurrences of abuse per policy.</p> <p>2. The record for Resident #9 was reviewed on 6/29/15 at 4:10 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and depression</p> <p>Review of Quarterly MDS Assessment dated 2/21/15, indicated the resident was cognitively impaired.</p> <p>Review of a incident investigation, dated 6/17/15, indicated on the afternoon of 6/16/15 Housekeeping #1 told CNA #2 that on 6/15/15 she thought CNA #1 was</p>			

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	<p>a little rough with Resident #9 during a transfer. CNA #2 reported the alleged abuse to the DON, who then reported it to the Administrator. The investigation indicated Housekeeping #1 received disciplinary action due to her failure to report abuse timely per facility policy.</p> <p>Interview with the Administrator on 6/29/15 at 4:27 p.m. indicated Housekeeping #1 should have reported the allegation of abuse to her immediately.</p> <p>A facility policy, dated 10/2014, and received as current from the Regional Director on 6/25/15 at 3:31 p.m., indicated "...This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of property are reported immediately to the administrator of the facility...If resident abuse, or suspicion of abuse, is reported:...4...A thorough investigation will be initiated...12. Statements will be taken including, but not limited to, facts and observations by involved employees...facts and observations by the licensed nurse or individual to whom the initial report was made..."</p> <p>3.1-28(a)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow the plan of care related to the lack of pulse monitoring for residents on a blood pressure medication, lack of daily skin checks for a resident with an immobilizer, lack of laboratory testing not completed as ordered and lack of a gradual dose reduction of an antipsychotic medication not completed as ordered for 3 of 22 residents whose plan of care was reviewed. (Residents #12, #7, and #30)</p> <p>Findings include:</p> <p>1. Record review for Resident #12 was completed on 6/25/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to hypertension, anxiety and depression.</p> <p>A Care Plan for hypertension indicated: the resident had a diagnosis of hypertension and was at risk for complications associated with it.</p> <p>Interventions included: administer</p>			F 0282	<p>I. 1. Resident #12 incurred no negative outcome as a result of staff not recording heart rate obtained prior to administering Metoprolol. 2. A full skin inspection of Resident #7 was conducted to ensure no negative outcome as a result of staff failure to document skin inspections on the Daily Device Skin Assessment. 3. The physician of Resident #30 has been notified of the lack of collection of stools for hemocult testing. No further orders were given. Resident #30 incurred no negative outcome as a result of staff not recording heart rate obtained prior to administering Metoprolol. Resident #30 remains on the correct dose of Seroquel (as per recommendation) as of 5/26/15.</p> <p>II. As all residents could be affected, licensed nursing staff will receive inservice training addressing following of physician orders, including but not limited to, adherence with obtaining and documenting vital signs as ordered prior to medication administration, physician notification per the ordered parameter, collection of</p>		07/29/2015

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	<p>medications as ordered.</p> <p>A Physician's Order Dated 5/27/15 at 8:30 a.m., indicated to add to Metoprolol (blood pressure medication): call physician if heart rate is less than 50.</p> <p>Review of the June 2015 POS (Physician Order Summary) indicated Metoprolol Tartrate 25 mg (milligrams). Give 1/2 tablet (12.5 mg) two times a day. Call physician if heart rate is less than 50.</p> <p>Review of the May and June 2015 MAR (Medication Administration Record) indicated the resident received Metoprolol on the following dates and times without the heart rate obtained before:</p> <p>5/27/15 at 6:00 p.m. 5/28/15 at 6:00 a.m., and 6:00 p.m. 5/29/15 at 6:00 a.m., and 6:00 p.m. 5/30/15 at 6:00 a.m., and 6:00 p.m. 5/31/15 at 6:00 a.m., and 6:00 p.m. 6/4/15 at 6:00 p.m. 6/5/15 at 6:00 p.m. 6/9/15 at 6:00 p.m. 6/10/15 at 6:00 p.m. 6/15/15 at 6:00 a.m. 6/16/15 at 6:00 p.m. 6/17/15 at 6:00 p.m.</p> <p>Interview with the Regional Director on</p>		<p>specimens (and physician notification should a specimen be unable to be collected), and timely communication of recommendation for dosage reduction as per clinician recommendation. Those residents with specific call parameters will be identified. The DON/ADON/Designee shall be responsible to monitor the medication administration records on scheduled days of work to confirm compliance with obtaining of ordered vital signs and following of any call parameters listed. III. As a means to ensure ongoing compliance, following aforementioned inservice training, monitoring will be conducted by the DON/ADON/Designee daily on scheduled days of work of all newly received physician orders and any clinician recommendations received relative to dosage reductions to confirm timely staff follow through. The DON/ADON/Designee shall be responsible to monitor the medication administration records on scheduled days of work to confirm compliance with obtaining of ordered vital signs and following of any call parameters listed. This will occur daily for two weeks, twice weekly for two weeks, weekly for four weeks, then monthly thereafter for a minimum of 6 months. Should non-compliance be observed, applicable nursing staff shall be</p>	

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	<p>6/25/15 at 4:30 p.m., indicated he was unable to find any indication the heart rate was obtained on the above dates and times before the medication was administered.</p> <p>Interview with the DON (Director of Nursing) on 6/29/15 at 11:23 a.m., indicated the staff should have taken the heart rate before administering the medication to the resident.</p> <p>2. On 6/24/15 at 11:55 a.m. Resident #7 was observed in the Main Dining Room seated in a Geri chair (a reclining chair with wheels). Her right leg was elevated on two pillows with her right heel floated; she had an immobilizer in place to her right leg and a podus boot (a soft boot used to prevent pressure on the heel) on her right foot.</p> <p>The record for Resident #7 was reviewed on 6/24/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and osteoarthritis.</p> <p>Review of the June 2015 Physician Order Summary indicated an order for Immobilizer right leg.</p> <p>A Physician's Order, dated 6/4/15, indicated an order for " 1. Brace x 8 more weeks. 2. May take off to shower.</p>		<p>addressed, re-educated and disciplinary action taken, if warranted. IV. Results of the monitoring will be discussed during the facility's quarterly QA meetings for a minimum of 6 months and the plan adjusted as indicated through the monitoring tools.</p>	

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	<p>3. Daily skin checks."</p> <p>The resident had a care plan for right femur fracture last updated 5/28/15. The interventions included daily skin checks.</p> <p>Review of the June 2015 Treatment Administration Record (TAR) indicated the Immobilizer to the right leg was signed off as in place every shift. The record lacked documentation to indicate daily skin checks had been completed.</p> <p>Review of the Daily Device Skin Assessment for June 2015 indicated the right leg immobilizer was to be on at all times. The Assessment was not completed for 6/1/15, 6/2/15, 6/5/15, 6/6/15, 6/7/15, 6/8/15, 6/12/15, 6/13/15, 6/14/15, 6/15/15, 6/16/15, 6/17/15, 6/18/15, 6/19/15, and 6/23/15.</p> <p>Interview with LPN #2 on 6/29/15 at 3:58 p.m. indicated the resident was to have the immobilizer on her right leg at all times. She further indicated she checked the residents skin each shift when she completed the resident's treatment to her right heel. She indicated there was no specific area where she charted the skin checks. She indicated if she noticed any new area she would start a skin sheet.</p>			

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	<p>Interview with the Regional Director on 6/25/15 at 3:20 p.m. indicated the Daily Device Skin Assessments had not been completed as ordered.</p> <p>A policy titled "Skin Management Program", dated 10/2013, received from the RN Consultant as current on 6/26/15 at 11: 05 a.m. indicated "...Residents who wear a device such as a splint, brace, immobilizer, etc. will have his/her affected limb(s) assessed daily by a licensed nurse due to greater risk of skin breakdown. See daily device skin assessment (to be house with the Treatment Administration Record to ensure the licensed nurse assesses the skin surrounding or under the device at least daily. This should be completed by the day shift nurse, unless otherwise specified)."</p> <p>3. The record for Resident #30 was reviewed on 6/24/15 at 4:02 p.m. The resident's diagnoses included, but were not limited to, bipolar disorder with behavioral agitation, hypertension, and atrial fibrillation.</p> <p>Review of the June 2015 Physician Order Summary (POS) indicated a laboratory order for annual hemoccult stool (a test for blood in the stool) x (times) 2 in December. There was also an order for</p>			

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	<p>Xarelto (a blood thinning medication) 10 mg (milligrams) every evening originally ordered on 8/21/14. The Xarelto medication had been discontinued on 6/9/15.</p> <p>There was lack of documentation in the record to indicate the hemocult stool tests had been completed as ordered in December.</p> <p>A Physician ' s Order, dated 5/22/15, indicated to start Metoprolol (a blood pressure medication) 50 mg twice a day, call MD (physician) if HR (heart rate) &lt; (less than) 50.</p> <p>The resident had a care plan for hypertension, last updated 6/9/15. The nursing interventions included, "Call MD (physician) if HR (heart rate) &lt; (less than) 50."</p> <p>Review of the May 2015 Medication Administration Record (MAR) indicated there was no pulse obtained prior to Metoprolol administration on the following dates: -5/23/15 at 8 am and 8 pm -5/24/15 at 8 am and 8 pm -5/25/15 at 8 am and 8 pm -5/26/15 at 8 am and 8 pm -5/27/15 at 8 am and 8 pm -5/28/15 at 8 am and 8 pm</p>			

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	<p>-5/29/15 at 8 am and 8 pm -5/30/15 at 8 am and 8 pm -5/31/15 at 8 am and 8 pm</p> <p>Review of the June 2015 MAR indicated there was no pulse obtained prior to the Metoprolol administration on the following dates: -6/1/15 at 8 am and 8 pm -6/2/15 at 8 am -6/5/15 at 8 am -6/6/15 at 8 am -6/10/15 at 8 am</p> <p>Review of a Physician's Order, dated 4/28/15, indicated an order to reduce Seroquel (an antipsychotic medication) to 12.5 mg daily.</p> <p>Review of the Interdisciplinary Team notes, dated 4/28/15, indicated the Nurse Practitioner had recommended to decrease Seroquel to 12.5 mg every day at this time.</p> <p>Review of the April 2015 MAR indicated the old order had been crossed out and the new order had been written on the MAR but not signed off on 4/29/15 and 4/30/15.</p> <p>Review of the 5/26/15 Psychiatric Progress Note indicated the Seroquel medication had not been reduced as</p>			

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	<p>ordered, the resident had received Seroquel 12.5 mg twice daily, and the resident was still due for a gradual dose reduction (GDR).</p> <p>Review of a Physician's Order, dated 5/26/15, indicated an order to reduce Seroquel to 12.5 mg daily.</p> <p>Review of the Interdisciplinary Team notes, dated 5/26/15, indicated "...d/t (due to) waiting on approval from rec (recommendation) last review, NP (Nurse Practitioner) rec (recommendation) to decrease Seroquel to 12.5 mg QD (every day) at this time."</p> <p>Interview with the ADON and Social Service Designee on 6/26/15 at 10:50 a.m. indicated there must have been a problem with the May rewrites and the reduced dose of Seroquel was not continued from April to May. They further indicated the resident had received the Seroquel 12.5 mg twice a day in May until it was reduced again on 5/26/15.</p> <p>Interview with the Regional Director on 6/26/15 at 11:12 a.m. indicated the December hemocult labs had not been completed as ordered.</p> <p>Interview with the Regional Director on</p>			

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F 0309 SS=D Bldg. 00	<p>6/26/15 at 11:37 a.m. indicated he could not find documentation the pulse had been taken prior to the Metoprolol administration on the above dates.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 2 of 3 residents reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non pressure related skin conditions. (Resident #13 and Resident #17)</p> <p>Findings include:</p> <p>1. On 6/22/15 at 2:14 p.m., Resident #13 was observed sitting on the side of her bed. The resident was observed to have a</p>	F 0309	<p>I. 1. A skin assessment of Resident #13 was completed and bruising accurately documented to reflect current resident status.</p> <p>2. A skin assessment of Resident #17 was completed to ensure any bruising/discoloration, etc. is accurately documented to reflect current resident status. II. As all residents could be affected, a full facility skin sweep will be conducted. Prior to said sweep, the facility will ensure assigned nursing staff are addressed as to identification of any bruising (new or fading), as well as any skin conditions to ensure accuracy of the skin sweep. All areas identified will be documented appropriately. III. As a means to ensure ongoing compliance,</p>	07/29/2015

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	<p>dark purple discoloration under her left eye. At the time of the observation the resident indicated the discoloration was from a recent fall she had. She further indicated the area was tender if she touched it.</p> <p>On 6/24/15 at 10:13 a.m., Resident #13 was observed lying in bed. The resident was observed to have a dark purple discoloration under her left eye. At the time of the observation the resident indicated it was hard to eat because of the soreness of her left cheek.</p> <p>Record review for Resident #13 was completed on 6/24/15 at 1:34 p.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, anxiety and depression.</p> <p>The Quarterly MDS (Minimum Data Set) assessment completed on 5/20/16 indicated the resident was cognitively intact. The assessment indicated the resident needed limited assistance of 1 person for walking and locomotion, and extensive 1 person assist for dressing.</p> <p>A Nursing Note dated 6/7/15 at 3:15 p.m., indicated the resident had fallen forward and hit her head on the wall. The Physician was notified and an order was given to send the resident to the</p>		<p>nursing staff shall receive inservice training as to the conducting of thorough skin observations and correct completion of the shower sheets, non-pressure skin monitoring records and weekly skin assessments as per facility Skin Management Program. Following said inservice training, the DON/ADON/Designee shall be responsible to monitor any admission/re-admission skin assessment, accidents and shower sheets on 10 residents as follows: daily for two weeks, weekly for two weeks, then monthly thereafter on an ongoing basis for a minimum of 6 months to ensure correct initiation and completion of appropriate documentation as per the facility Skin Management Program. Should non-compliance with correct completion be identified, applicable staff shall be re-educated and disciplinary action taken, as warranted. IV. As a means of quality assurance, findings of the aforementioned audits and any corrective actions taken shall be reported to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months and the plan adjusted as indicated through the monitoring forms.</p>		

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	<p>emergency room.</p> <p>A Nursing Note dated 6/8/15 at 12:45 a.m., indicated the resident returned from the hospital with sutures to the left forehead and bright purple bruising periorbital (around the eye) left eye.</p> <p>A Nursing Note dated 6/8/15 at 2:00 a.m., indicated eye was purple in color.</p> <p>A Nursing Note dated 6/9/15 at 3:20 unable to determine if it was a.m., or p.m., indicated purple periorbital bruising continues to left side.</p> <p>Review of Shower/Bath sheets completed from 6/9/15 to 6/23/15 lacked any indication the resident had the purple discoloration to the left eye.</p> <p>Review of Weekly Skin Assessments completed on 6/11/15 and 6/18/15 indicated no new skin alteration.</p> <p>A Nursing Assessment completed on 6/15/15 indicated the resident's skin condition was warm and dry. The assessment further indicated to see skin sheets for any alterations in skin integrity which included bruising.</p> <p>Review of skin sheets for non-pressure related skin conditions lacked a skin</p>			

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	<p>sheet for the purple discoloration around the resident's left eye.</p> <p>Review of the Nursing Notes' from 6/9/15 to present lacked any indication the resident's purple discoloration around her left eye was being monitored.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 6/24/15 at 3:15 p.m., indicated the resident should have had a skin assessment sheet completed if the resident had a discoloration. She further indicated she would look in to it.</p> <p>Interview with the ADON on 6/25/15 at 3:32 p.m., indicated when the resident came back from the hospital on June 8th a skin assessment sheet should have been filled out and the discoloration should have been measured and continuously monitored until it was healed. She further indicated she was unable to find any documentation the discoloration had been measured or was being monitored. She further indicated the facility completed a skin assessment sheet on 6/24/15 of the discoloration which included the measurement and color.</p> <p>Interview with DON (Director of Nursing) on 6/29/15 at 11:23 a.m., indicated the resident's discoloration should have been measured and</p>			

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	<p>monitored continuously until healed.</p> <p>2. Resident #17 was observed on 6/22/15 at 10:47 AM. A quarter-sized faded reddish area was noted to her left forearm. At the time of the observation, the resident indicated she had "bumped it on something."</p> <p>On 6/25/15 at 9:39 AM, Resident #17 was observed resting in her recliner in her room. A quarter-sized fading reddish area remained to her left forearm. At that time, she indicated, "it's finally starting to go away." She further indicated the area had been there for "three weeks or so," and staff had done a full skin assessment the night before.</p> <p>On 6/25/15 at 9:43 AM, the DON (Director of Nursing) indicated the corporate staff had completed a skin sweep of all the residents the previous night and there were no skin areas found or currently being monitored for Resident #17.</p> <p>Resident #17 was observed with the DON on 6/25/15 at 9:46 AM. The DON also noted the fading reddened area to the resident's left forearm and indicated this was the first time she was aware of the area. She further indicated the area should have been caught at some point with weekly skin assessments even</p>						

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	<p>though the resident was independent with ADLs (Activities of Daily Living).</p> <p>Resident #17's record was reviewed on 6/25/15 at 9:25 AM. Diagnoses included, but were not limited to, tremulousness, weight loss, anemia, anxiety, and chronic pain.</p> <p>Review of the Quarterly MDS (Minimum Data Set) Assessment dated 5/13/15 indicated the resident was cognitively intact.</p> <p>Shower sheets for June 2015 were reviewed and indicated the resident does per self.</p> <p>Review of the skin monitoring log book indicated there were no areas currently monitored for Resident #17.</p> <p>Weekly skin assessments dated 6/3/15 and 6/10/15 indicated "no skin alterations noted, skin remains intact." Weekly skin assessments dated 6/18/15 and 6/25/15 indicated "No NEW skin alteration &amp; existing areas being monitored," but the DON and LPN #1 both indicated they were not aware of any areas being monitored and felt it was checked in error. A note on the weekly skin assessment sheet dated 6/24/15 indicated, "No areas noted. Skin assessment</p>			

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	<p>completed."</p> <p>Review of Nurses' Notes for June 2015 lacked any mention of bruising to Resident #17's left forearm. A note dated 6/24/15 (at) 2000 (8:00 PM) indicated, "Skin assessment completed. Skin W/D/I (warm/ dry/ intact). [No] concerns."</p> <p>A new non-pressure skin sheet was initiated by the ADON (Assistant DON) on 6/25/15 indicating a newly observed bruise to Resident #17's left forearm measuring 2.0 cm (centimeters) x 1.7 cm, color dark pink.</p> <p>Review of Resident #17's care plans indicated a care plan for "Pressure ulcer risk", which included the interventions: head to toe skin assessment at least weekly by a licensed nurse; staff to observe skin condition while providing care; notify the charge nurse of any skin problems for further assessment and possible Physician and responsible party notification.</p> <p>A new care plan was initiated on 6/25/15 by the ADON for "BRUISE: L FA (left forearm)".</p> <p>A policy titled "Skin Management Program" was provided by the ADON on 6/25/15 at 10:20 AM and deemed as</p>			

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	<p>current. The policy indicated, "Policy: This facility will assess/ identify the presence of risk factors that may contribute to the development of pressure ulcers and other skin alterations in an effort to prevent skin breakdown and/or further deterioration limited by the individual's recognized pathology and pre-existing co-morbid conditions. ASSESSMENT/ DOCUMENTATION/ MONITORING: ... Should a pressure or non-pressure related skin condition be identified, the licensed nurse will begin the completion of the appropriate initial assessment/ ongoing monitoring form which is then placed in the "Skin Binder." ... Residents who wear a device such as a splint, brace, immobilizer, etc. will have his/ her affected limb(s) assessed daily by a licensed nurse due to greater risk of skin breakdown. See Daily Device Skin Assessment (to be housed with the Treatment Administration Record to ensure the licensed nurse assesses the skin surrounding or under the device at least daily. This should be completed by the day shift nurse, unless otherwise specified.) A resident with a newly identified skin condition will have the appropriate assessment ongoing monitoring form initiated on the basis of the "type" of skin condition. See Initial Assessment/ Ongoing Monitoring for Non-Pressure Related Skin Conditions</p>			

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F 0314 SS=G Bldg. 00	<p>(to be housed in the "Skin Binder" and remain in place until the skin condition is clear/ healed for <u>at least two weeks</u>, at which time it is moved to the "Assessments" section of the medical record.) ...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, record review, and interview the facility failed to ensure a treatment was obtained when a new pressure area was observed resulting in worsening of the pressure ulcer, follow physician orders, and ensure each resident maintained acceptable parameters of nutrition related to following through with dietary recommendations for 1 of 3 residents reviewed for pressure ulcers of the 15 who met the criteria for pressure ulcers.</p>	F 0314	<p>1. A skin assessment of Resident #7 was completed to ensure all areas accurately documented to reflect current resident status. Daily device monitoring has been initiated relative to the immobilizer in place, and the RD has reviewed Resident #7 relative to any recommendations to enhance healing. II. As all residents could be affected, a full facility skin sweep will be conducted. Prior to said sweep, the facility will ensure assigned nursing staff are addressed as to identification of</p>	07/29/2015

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	<p>This resulted in a deterioration of the wound from a suspected Deep Tissue Injury (DTI) to an Unstageable pressure ulcer. (Resident #7)</p> <p>Finding includes:</p> <p>On 6/24/15 at 11:55 a.m. Resident #7 was observed in the Main Dining Room seated in a Geri chair (a reclining chair with wheels). Her right leg was elevated on two pillows with her right heel floated; she had an immobilizer in place to her right leg and a podus boot (a soft boot used to prevent pressure on the heel) on her right foot.</p> <p>On 6/26/15 at 3:34 p.m. Resident #7 was observed lying in bed. The resident had a specialty bed which was a low air loss mattress. The ADON had just removed the resident's dressings from her right ankle and her right heel. The whole bottom of the resident's right heel was observed to be black in color. The skin over the black area was observed to be open. The area to the resident's right lateral ankle was observed to be about the size of a penny with a smaller open area in the middle with a screw head visible. The area around the open area was observed to be reddened. Interview with the ADON at the time of the observation indicated she had been debriding both</p>		<p>any bruising (new or fading), as well as any skin conditions to ensure accuracy of the skin sweep. All areas identified will be documented appropriately. All residents with areas and/or devices in place shall be reviewed to ensure appropriate documentation is in place for necessary monitoring. Audit shall be conducted to confirm applicable residents have been reviewed by the registered dietitian and any recommendations communicated to the physician and initiated, as applicable. III. As a means to ensure ongoing compliance, nursing staff shall receive inservice training as to the facility Skin Management Program, including but not limited to physician notification, following physician orders and follow through with dietary recommendations. Following said inservice training, the DON/ADON/Designee shall be responsible to monitor compliance with the facility Skin Management Program. Ten residents will be reviewed on scheduled work days as follows: daily for two weeks, weekly for two weeks, then monthly thereafter on an ongoing basis for a minimum of six months. Should non-compliance with elements of the management program be identified, applicable staff shall be re-educated and disciplinary action taken, as warranted. IV. As</p>				

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	<p>areas and this was the first time the screw head had been visible to the right ankle. She further indicated the area to the right heel looked about the same as it had last week.</p> <p>The record for Resident #7 was reviewed on 6/24/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and osteoarthritis.</p> <p>The 5/13/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident was at risk for pressure ulcers, currently had no unhealed pressure ulcers, and was cognitively impaired.</p> <p>A care plan dated 5/15/15 indicated the resident had a pressure ulcer/suspected DTI to the right heel. The interventions included: "...monitor per skin management program...monitor treatment efficacy/if ulcer not improving consult physician...podus boot to right foot at all times..."</p> <p>An Initial Pressure Ulcer Assessment for the right heel was initiated on 5/15/15. The assessment indicated a suspected DTI began on the right heel on 5/15/15. The size measured 2.5 x 1 3/4 cm (centimeters). There was no depth, no exudate (drainage), no wound associated</p>		<p>a means of quality assurance, findings of the aforementioned monitoring and any corrective actions taken shall be reported to the Quality Assurance Committee on a quarterly basis for a minimum of 6 months and the plan adjusted as indicated through the monitoring forms.</p>	

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	<p>pain, and no tunneling/undermining. The assessment indicated the wound bed was "deep red purple" and the wound edges were flat. The assessment indicated the Physician and resident's legal representative were notified on 5/15/15 and "keep heel elevated off bed" was written on the bottom of the form.</p> <p>On 5/20/15 the Pressure Ulcer Assessment for the right heel indicated the suspected DTI area measured 2.5 x 1.8 cm, the depth was undetermined, there was no exudate, no tunneling/undermining, and no wound associated pain. The wound bed was "deep red/purple" and the wound edges were "flat pink."</p> <p>On 5/27/15 the Pressure Ulcer Assessment for the right heel indicated the suspected DTI area measured 3.5 x 3.5 cm, the depth was undetermined, there was no exudate, no tunneling/undermining, and no associated wound pain. The wound bed was "red/purple" and the wound edges were "flat pink."</p> <p>On 6/3/15 the Pressure Ulcer Assessment for the right heel indicated the suspected DTI area measured 3.5 x 3.5 cm, the depth was undetermined, there was no exudate, no tunneling/undermining, and</p>			

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	<p>no associated wound pain. The wound bed was "red/purple" and the wound edges were "flat pink."</p> <p>On 6/10/15 the Pressure Ulcer Assessment for the right heel indicated the suspected DTI area measured 2.5 x 4.7 cm, the depth was undetermined, there was no exudate, no tunneling/undermining, and no associated wound pain. The wound bed was "deep purple" and the wound edges were "flat pink."</p> <p>A Nurse's Note, dated 6/11/15 at 4 p.m., indicated two new pressure areas were noted. A stage II area to the right buttocks that measured 1.5 x 2.5 x &lt; (less than) 0.1 cm and an unstageable area to the right ankle that measured 0.7 x 0.5 cm x undetermined depth. The Nurse's Note indicated "...requested tx (treatment) orders from MD (Physician). MD et (and) POA (power of attorney) aware." There was lack of documentation to indicate a treatment order was obtained or the facility followed up with the Physician.</p> <p>A Nurse's Note, dated 6/14/15 at 11:45 p.m., indicated "...New area noted on skin sheet on previous shift et fax sent to PCP (primary care physician)." There was no indication a treatment order was</p>			

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	<p>obtained or the facility followed up with the Physician.</p> <p>An Initial Pressure Ulcer Assessment for the right upper buttocks was initiated on 6/14/15. The assessment indicated a stage II pressure ulcer began on the right upper buttocks on 6/14/15. The stage II area measured 2.9 x 1.6 cm, serosanguinous (serous fluid with blood) exudate, no tunneling/undermining, red wound bed and red wound edges. The assessment indicated the Physician was notified on 6/14/15 via fax and the resident's legal representative was notified.</p> <p>A Physician's Order, dated 6/16/15, indicated treatment orders for the right heel wound, the right outer ankle wound, and the buttock's wounds.</p> <p>Review of the June 2015 Treatment Administration Record (TAR) indicated the daily treatments to the right heel wound, the right outer ankle wound, and the buttocks wound were started on 6/17/15 on the afternoon shift.</p> <p>There was no indication in the record that any treatment orders had been obtained prior to 6/16/15 or implemented to the right heel, right outer ankle, and buttocks pressure areas until 6/17/15.</p>			

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	<p>On 6/17/15 the Pressure Ulcer Assessment for the right heel indicated the area was now considered unstageable. The unstageable area measured 3 x 7 cm, the depth was undetermined, there was no exudate, undetermined tunneling/undermining, and no associated wound pain. The wound bed was "black" and the wound edges were "pink WNL (within normal limits)." The assessment indicated the Physician and the resident's legal representative were updated on 6/18/15.</p> <p>On 6/18/15 the Pressure Ulcer Assessment for the right upper buttocks indicated the stage II area to the right upper buttocks and the stage II area to the right buttocks had combined and were now an unstageable area measuring 8 x 11 cm, the depth was undetermined, there was moderate serous exudate, no tunneling/undermining, and no associated wound pain. The wound bed was "areas of deep red et purple. Open areas noted" and the wound edges were "pink denuded."</p> <p>An Interdisciplinary Team Note, dated 6/19/15, indicated "...right heel unstageable 3.0 x 5.0 depth is unable to determined (sic)-worsened, right ankle unstageable 1.0 x 1.0 depth unable to be</p>			

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	<p>determined-worsened, buttocks unstageable 8 x 11 depth unable to determine-worsened..."</p> <p>A Nurse's Note, dated 6/22/15 at 5 p.m., indicated "...noted sig (significant) change in wound on buttocks-area noted to be 8.0 cm x 11.0 cm x UTD (undetermined)-unstageable...MD et POA aware. Spoke with POA in detail regarding changes to res (resident) condition..."</p> <p>On 6/24/15 the Pressure Ulcer Assessment for the right heel indicated the area was unstageable. The unstageable area measured 5.2 x 2.5 cm. There was no depth, no exudate, no tunneling/undermining and no wound associated pain. The wound bed was "eschar boggy" and the wound edges were "flat".</p> <p>On 6/24/15 the Pressure Ulcer Assessment for the right ankle indicated the area was now a stage III. The stage III area measured 1.0 x 0.6 x &lt;0.1 cm. There was yellow exudate, no tunneling/undermining, and no wound associated pain. The wound bed was "red" and the wound edges were "scabbed."</p> <p>Review of the June 2015 Physician Order</p>			

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	<p>Summary indicated an order for Immobilizer right leg.</p> <p>A Physician's Order, dated 6/4/15, indicated an order for " 1. Brace x 8 more weeks. 2. May take off to shower. 3. Daily skin checks."</p> <p>The resident had a care plan for right femur fracture last updated 5/28/15. The interventions included daily skin checks.</p> <p>Review of the June 2015 Treatment Administration Record (TAR) indicated the Immobilizer to the right leg was signed off as in place every shift. The record lacked documentation to indicate daily skin checks had been completed.</p> <p>Review of the Daily Device Skin Assessment for June 2015 indicated the right leg immobilizer was to be on at all times. The Assessment was not completed for 6/1/15, 6/2/15, 6/5/15, 6/6/15, 6/7/15, 6/8/15, 6/12/15, 6/13/15, 6/14/15, 6/15/15, 6/16/15, 6/17/15, 6/18/15, 6/19/15, and 6/23/15.</p> <p>Interview with LPN #2 on 6/29/15 at 3:58 p.m. indicated the resident was to have the immobilizer on her right leg at all times. She further indicated she checked the residents skin each shift when she completed the resident's</p>			

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	<p>treatment to her right heel. She indicated there was no specific area where she charted the skin checks. She indicated if she noticed any new area she would start a skin sheet.</p> <p>Interview with the RN Consultant on 6/25/15 at 213 p.m. indicated the wound nurse had been in to see the resident and indicated the areas to the resident's buttocks were not one big combined area but four separate areas. She further indicated the wound nurse had not agreed with the wound staging of unstageable and new pressure ulcer assessment skin sheets had been completed.</p> <p>An Initial Pressure Ulcer Assessment for near coccyx and right buttocks was initiated on 6/24/15. The assessment indicated the area near the coccyx/right buttocks was a stage III and measured 1.8 x 0.8 x &lt;0.1 cm. The assessment indicated the Physician and resident's legal representative were notified on 6/24/15.</p> <p>An Initial Pressure Ulcer Assessment for right buttock/lower buttock was initiated on 6/24/15. The assessment indicated the area on the right buttock/lower buttock was a stage I and measured 7 x 2 cm. The assessment indicated the Physician and resident's legal representative were</p>			

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	<p>notified on 6/24/15.</p> <p>An Initial Pressure Ulcer Assessment for the left buttock was initiated on 6/24/15. The assessment indicated the area to the left buttock was a stage II and measured 2 x 0.5 x &lt;0.1 cm. The assessment indicated the Physician and resident's legal representative were notified on 6/24/15.</p> <p>An Initial Pressure Ulcer Assessment for the right buttock was initiated on 6/24/15. The assessment indicated the area to the right buttock was a stage III and measured 1.2 x 1 x &lt;0.1 cm. The assessment indicated the Physician and resident's legal representative were notified on 6/24/15.</p> <p>Review of the Nutritional Progress Notes, dated 4/28/15, indicated the resident had a significant weight loss of 9.4% in the last 3 months. The note indicated a recommendation to increase Boost to QID (four times a day). The record lacked documentation the Boost had been given four times a day.</p> <p>Review of the Annual Nutritional Assessment, dated 6/16/15, indicated the resident had a non significant weight loss of 3.1% in the last 30 days. The assessment indicated a recommendation</p>			

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	<p>to change the multivitamin to a multivitamin with minerals and to consider an appetite stimulant. The record lacked documentation the multivitamin order had been changed to multivitamin with minerals and that the resident had received any appetite stimulant.</p> <p>Interview with the Regional Director on 6/25/15 at 3:20 p.m. indicated on 5/15/15 when the suspected DTI was noted the new intervention was to elevate the heel. He indicated the resident had already had a podus boot and air mattress in place prior to the identification of the DTI. He indicated the Daily Device Skin Assessments for the immobilizer had not been completed as ordered and the dietary recommendations had not been followed up on. He further indicated he could see where the stage II to the buttocks on 6/11/14, unstageable to the right ankle on 6/11/15, and stage II to the right upper buttocks on 6/14/15 had been identified and no treatment had been started to those areas prior to 6/17/15. He further indicated the Physician was notified by fax on 6/11/15 of the request for treatment orders and the treatment orders were not obtained until 6 days later. He indicated there had been a delay in treatment and staff should have followed up with the Physician sooner</p>			

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	<p>before the areas got worse.</p> <p>A policy titled "Skin Management Program", dated 10/2013, received from the RN Consultant as current on 6/26/15 at 11: 05 a.m. indicated "...Residents who wear a device such as a splint, brace, immobilizer, etc. will have his/her affected limb(s) assessed daily by a licensed nurse due to greater risk of skin breakdown. See daily device skin assessment (to be house with the Treatment Administration Record to ensure the licensed nurse assesses the skin surrounding or under the device at least daily. This should be completed by the day shift nurse, unless otherwise specified)."</p> <p>A policy titled "Skin Management Program", dated 10/2013, received from the RN Consultant as current on 6/26/15 at 11: 05 a.m. indicated "...Residents who wear a device such as a splint, brace, immobilizer, etc. will have his/her affected limb(s) assessed daily by a licensed nurse due to greater risk of skin breakdown. See daily device skin assessment (to be house with the Treatment Administration Record to ensure the licensed nurse assesses the skin surrounding or under the device at least daily. This should be completed by the day shift nurse, unless otherwise</p>			

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	<p>specified)...Interventions will be implemented according to the individual resident's risk factors in an effort tot reduce the risk of development of pressure ulcers and/or promote the most effective healing of existing areas. Prevention and treatment interventions will include but are not limited to nutritional support, pressure reducing devices, assistance with turning, repositioning and hygiene, physical or occupational therapy, restorative nursing, and physician/wound specialist consultation...Notification of physician and resident or legal representative shall occur upon initial observation of a new skin condition and periodically thereafter in an effort to address continued healing or lack thereof..."</p> <p>A policy titled "Notification of Change", dated 10/2014, received from the Administrator as current on 6/25/15 at 3:04 p.m. indicated "...If a response to the faxed notification/information is not received in an acceptable time frame, the physician's office will be contacted per telephone and response requested by the facility in an effort to provide the resident with any potentially needed care/intervention..."</p> <p>3.1-40(a)(2)</p>			

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F 0325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident maintained acceptable parameters of nutrition related to following through with dietary recommendations for 1 of 3 residents reviewed for pressure ulcers of the 15 who met the criteria for pressure ulcers. (Resident #7)</p> <p>Finding includes:</p> <p>The record for Resident #7 was reviewed on 6/24/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and osteoarthritis.</p> <p>Review of the Nutritional Progress Notes, dated 11/21/14, indicated the resident had a significant weight loss of 10.1 % in the last 180 days. The note indicated a recommendation for Boost (a nutritional</p>	F 0325	<p>The facility failed to ensure each resident maintained acceptable parameters of nutrition related to following through with dietary recommendations for 1 of 3 residents reviewed for pressure ulcers of the 15 who met the criteria for pressure ulcers. (Resident #7) I. Resident #7 has been assessed by the RD to confirm any recommendations warranted are in place. II. Those residents with pressure ulcers have been reviewed by the RD to confirm any recommendations warranted are in place. III. As a means to ensure ongoing compliance, nursing staff shall receive inservice training as to the facility Skin Management Program, including but not limited to follow through with dietary recommendations. Following said inservice training, the DON/ADON/Designee shall be responsible to monitor compliance therewith per weekly monitoring of the program. Should non-compliance with</p>	07/29/2015	

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	<p>drink) at bedtime as well as a request for an appetite stimulant. The record lacked documentation the resident received any appetite stimulant.</p> <p>Review of the Annual Nutritional Assessment, dated 12/19/14, indicated the resident had a weight loss of 11% in the last 180 days and it was a significant weight loss. The assessment summary indicated no appetite stimulant had been started and a recommendation was made for a multivitamin with minerals and vitamin c 250 mg (milligrams) BID (twice a day).</p> <p>Review of the June 2015 Physician Order Summary (POS) indicated an order for Multivitamin tablet, 1 tablet by mouth every day, had been ordered on 12/22/14. There was lack of documentation to indicate a multivitamin with minerals had been ordered.</p> <p>Review of the Nutritional Progress Notes, dated 4/28/15, indicated the resident had a significant weight loss of 9.4% in the last 3 months. The note indicated a recommendation to increase Boost to QID (four times a day). The record lacked documentation the Boost had been given four times a day.</p> <p>Review of the Annual Nutritional</p>		<p>elements of the management program (including follow through with dietary recommendations) be identified, applicable staff shall be re-educated and disciplinary action taken, as warranted. IV. As a means of quality assurance, findings of the aforementioned monitoring and any corrective actions taken shall be reported to the Quality Assurance Committee on a quarterly basis. Frequency of monitoring shall be increased or decreased in response to monitoring results.</p>	

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	<p>Assessment, dated 6/16/15, indicated the resident had a non significant weight loss of 3.1% in the last 30 days. The assessment indicated a recommendation to change the multivitamin to a multivitamin with minerals and to consider an appetite stimulant. The record lacked documentation the multivitamin order had been changed to multivitamin with minerals and that the resident had received any appetite stimulant.</p> <p>Interview with the Regional Director on 6/25/15 at 3:20 p.m. indicated the dietary recommendations had not been followed up on.</p> <p>A policy titled "Skin Management Program", dated 10/2013, received from the RN Consultant as current on 6/26/15 at 11: 05 a.m. indicated "...Interventions will be implemented according to the individual resident's risk factors in an effort to reduce the risk of development of pressure ulcers and/or promote the most effective healing of existing areas. Prevention and treatment interventions will include but are not limited to nutritional support..."</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p>						

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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medications related to lack of pulse monitoring for residents on a blood pressure medication, laboratory testing not completed as ordered, a gradual dose reduction of an antipsychotic medication not completed as ordered, and a lack of an AIMS (Abnormal Involuntary Movement Scale) assessment for a resident receiving an antipsychotic medication for 3 of 5 residents reviewed for unnecessary</p>	F 0329	<p>I. 1. Resident #12 incurred no negative outcome as a result of staff not recording heart rate obtained prior to administering Metoprolol. 2..The physician of Resident #30 has been notified of the lack of collection of stools for hemoccult testing. No further orders were given. Resident #30 incurred no negative outcome as a result of staff not recording heart rate obtained prior to administering Metoprolol. Resident #30 remains on the correct dose of Seroquel (as per recommendation) as of 5/26/15.</p>	07/29/2015

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	<p>medications. (Residents #12, #30, and #38)</p> <p>Findings include:</p> <p>1. Record review for Resident #12 was completed on 6/25/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to hypertension, anxiety and depression.</p> <p>The MDS (Minimum Data Set) assessment completed on 4/22/15, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 14 which indicated the resident was cognitively intact. The assessment further indicated the resident had a diagnosis of hypertension.</p> <p>A Physician's Order Dated 5/27/15 at 8:30 a.m., indicated to add to Metoprolol (blood pressure medication): call physician if heart rate is less than 50.</p> <p>Review of the June 2015 POS (Physician Order Summary) indicated Metoprolol Tartrate 25 mg (milligrams). Give 1/2 tablet (12.5 mg) two times a day. Call physician if heart rate is less than 50.</p> <p>Review of the May and June 2015 MAR (Medication Administration Record) indicated the resident received</p>		<p>3. A baseline AIMS has been completed for Resident #38. II. As all residents could be affected, licensed nursing staff will receive inservice training addressing following of physician orders, including but not limited to, adherence with obtaining and documenting vital signs as ordered prior to medication administration, physician notification per the ordered parameter, collection of specimens (and physician notification should a specimen be unable to be collected), timely communication of recommendation for dosage reduction as per clinician recommendation, and completion of an AIMS as per facility policy for those residents receiving an antipsychotic. Those residents with specific call parameters will be identified. The DON/ADON/Designee shall be responsible to monitor the medication administration records on scheduled days of work to confirm compliance with obtaining of ordered vital signs and following of any call parameters listed. All residents with ordered antipsychotic medication have been identified and an AIMS will be completed if due. A schedule of ongoing assessment completion will be maintained by the DON/Designee. III. As a means to ensure ongoing compliance, following aforementioned inservice training,</p>				

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	<p>Metoprolol on the following dates and times without the heart rate obtained before:</p> <p>5/27/15 at 6:00 p.m. 5/28/15 at 6:00 a.m., and 6:00 p.m. 5/29/15 at 6:00 a.m., and 6:00 p.m. 5/30/15 at 6:00 a.m., and 6:00 p.m. 5/31/15 at 6:00 a.m., and 6:00 p.m. 6/4/15 at 6:00 p.m. 6/5/15 at 6:00 p.m. 6/9/15 at 6:00 p.m. 6/10/15 at 6:00 p.m. 6/15/15 at 6:00 a.m. 6/16/15 at 6:00 p.m. 6/17/15 at 6:00 p.m.</p> <p>Interview with the Regional Director on 6/25/15 at 4:30 p.m., indicated he was unable to find any indication the heart rate was obtained on the above dates and times before the medication was administered.</p> <p>Interview with the DON (Director of Nursing) on 6/29/15 at 11:23 a.m., indicated the staff should have taken the heart rate before administering the medication to the resident.</p> <p>2. The record for Resident #30 was reviewed on 6/24/15 at 4:02 p.m. The resident's diagnoses included, but were not limited to, bipolar disorder with behavioral agitation, hypertension, and</p>		<p>monitoring will be conducted by the DON/ADON/Designee daily on scheduled days of work of all newly received physician orders and any clinician recommendations received relative to dosage reductions to confirm timely staff follow through. Any resident with a newly ordered antipsychotic will have an AIMS completed as per facility policy. The DON/ADON/Designee shall be responsible to monitor the medication administration records on scheduled days of work to confirm compliance with obtaining of ordered vital signs and following of any call parameters listed. This will occur daily for one week, then weekly thereafter on an ongoing basis for a minimum of 6 months. Should non-compliance be observed, applicable nursing staff shall be addressed, re-educated and disciplinary action taken, if warranted. IV. As a means of quality assurance, results of the aforementioned audits and any corrective actions taken shall be reported to the QA Committee during quarterly meetings for a minimum of 6 months and the plan adjusted if indicated through the monitoring forms.</p>				

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	<p>atrial fibrillation.</p> <p>Review of the June 2015 Physician Order Summary (POS) indicated a laboratory order for annual hemocult stool (a test for blood in the stool) x (times) 2 in December. There was also an order for Xarelto (a blood thinning medication) 10 mg (milligrams) every evening originally ordered on 8/21/14. The Xarelto medication had been discontinued on 6/9/15.</p> <p>There was lack of documentation in the record to indicate the hemocult stool tests had been completed as ordered in December.</p> <p>A Physician ' s Order, dated 5/22/15, indicated to start Metoprolol (a blood pressure medication) 50 mg twice a day, call MD (physician) if HR (heart rate) &lt; (less than) 50.</p> <p>Review of the May 2015 Medication Administration Record (MAR) indicated there was no pulse obtained prior to Metoprolol administration on the following dates:</p> <ul style="list-style-type: none"> <li>-5/23/15 at 8 am and 8 pm</li> <li>-5/24/15 at 8 am and 8 pm</li> <li>-5/25/15 at 8 am and 8 pm</li> <li>-5/26/15 at 8 am and 8 pm</li> <li>-5/27/15 at 8 am and 8 pm</li> </ul>			

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	<p>-5/28/15 at 8 am and 8 pm -5/29/15 at 8 am and 8 pm -5/30/15 at 8 am and 8 pm -5/31/15 at 8 am and 8 pm</p> <p>Review of the June 2015 MAR indicated there was no pulse obtained prior to the Metoprolol administration on the following dates: -6/1/15 at 8 am and 8 pm -6/2/15 at 8 am -6/5/15 at 8 am -6/6/15 at 8 am -6/10/15 at 8 am</p> <p>Review of a Physician's Order, dated 4/28/15, indicated an order to reduce Seroquel (an antipsychotic medication) to 12.5 mg daily.</p> <p>Review of the Interdisciplinary Team notes, dated 4/28/15, indicated the Nurse Practitioner had recommended to decrease Seroquel to 12.5 mg every day at this time.</p> <p>Review of the April 2015 MAR indicated the old order had been crossed out and the new order had been written on the MAR but not signed off on 4/29/15 and 4/30/15.</p> <p>Review of the 5/26/15 Psychiatric Progress Note indicated the Seroquel</p>			

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	<p>medication had not been reduced as ordered, the resident had received Seroquel 12.5 mg twice daily, and the resident was still due for a gradual dose reduction (GDR).</p> <p>Review of a Physician's Order, dated 5/26/15, indicated an order to reduce Seroquel to 12.5 mg daily.</p> <p>Review of the Interdisciplinary Team notes, dated 5/26/15, indicated "...d/t (due to) waiting on approval from rec (recommendation) last review, NP (Nurse Practitioner) rec (recommendation) to decrease Seroquel to 12.5 mg QD (every day) at this time."</p> <p>Interview with the ADON and Social Service Designee on 6/26/15 at 10:50 a.m. indicated there must have been a problem with the May rewrites and the reduced dose of Seroquel was not continued from April to May. They further indicated the resident had received the Seroquel 12.5 mg twice a day in May until it was reduced again on 5/26/15.</p> <p>Interview with the Regional Director on 6/26/15 at 11:12 a.m. indicated the December hemocult labs had not been completed as ordered.</p>			

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	<p>Interview with the Regional Director on 6/26/15 at 11:37 a.m. indicated he could not find documentation the pulse had been taken prior to the Metoprolol administration on the above dates.</p> <p>3. The record for Resident #38 was reviewed on 6/26/15 at 11:19 a.m. The resident's diagnoses included, but were not limited to, paranoid organic psychosis, pseudobulbar affect, and vascular dementia with behaviors.</p> <p>Review of the June 2015 Physician Order Summary indicated an order for olanzapine (Zyprexa, an antipsychotic medication) 2.5 mg twice daily originally ordered on 10/17/14.</p> <p>Review of the June 2015 Medication Administration Record indicated the resident had received the olanzapine medication twice daily.</p> <p>Review of the Abnormal Involuntary Movement Scale (AIMS) assessment indicated the resident had last been assessed on 11/13/14.</p> <p>Interview with Director of Nursing on 6/26/15 at 3:00 p.m. indicated an AIMS assessment should be completed every 6 months. She further indicated she was unsure why one had not been completed</p>			

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F 0385 SS=D Bldg. 00	<p>since 11/13/14 and she would look into it.</p> <p>Interview with the DON on 6/29/15 at 1:53 p.m. indicated she had not completed an AIMS assessment since 11/13/14.</p> <p>An undated facility policy titled "AIMS (Abnormal Involuntary Movement Scale)", received as current from the Regional Director on 6/29/15 at 2:58 p.m., indicated "...1. The AIMS shall be completed within 14 days of initiation of psychotropic medication (baseline), with new onset of signs/symptoms of tardive dyskinesia and every 6 months after..."</p> <p>3.1-48(a)(6) 3.1-48(b)(2)</p> <p>483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p>			

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	<p>Based on record review and interview, the facility failed to ensure a resident's personal physician responded timely after an attempt was made to contact the physician related to pressure ulcers for 1 of 1 residents reviewed for notification of change. (Resident #7)</p> <p>Finding includes:</p> <p>The record for Resident #7 was reviewed on 6/24/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and osteoarthritis.</p> <p>A Nurse's Note, dated 6/11/15 at 4 p.m., indicated two new pressure areas were noted. A stage II area to the right buttocks that measured 1.5 x 2.5 x &lt; (less than) 0.1 cm and an unstageable area to the right ankle that measured 0.7 x 0.5 cm x undetermined depth. The Nurse's Note indicated "...requested tx (treatment) orders from MD (Physician). MD et (and) POA (power of attorney) aware." There was lack of documentation to indicate a treatment order was obtained or the facility followed up with the Physician.</p> <p>A Nurse's Note, dated 6/14/15 at 11:45 p.m., indicated "...New area noted on skin sheet on previous shift et fax sent to</p>	F 0385	<p>I. A skin assessment of Resident #7 was completed to ensure all areas accurately documented to reflect current resident status with orders for treatment in place. II. As all residents could be affected by untimely physician response, the following action shall be taken: Nursing will be responsible to notify physician via fax, if the fax is not responded upon in an acceptable time frame by the physician. The physician office will be contacted via telephone and request a response by the facility in effort to provide the residents with any potentially needed care and or intervention. III. As a means to ensure ongoing compliance, nursing staff shall be educated as to the facility policy addressing physician notification. Following said education, the DON/ADON/Designee shall be responsible to monitor the 24 hour report, lab reports and incident reports daily on scheduled days of work on an ongoing basis to confirm timely physician notification and physician response. Should staff non-compliance with policy be identified, necessary corrective action including re-education and/or disciplinary action shall be taken, as warranted. Should a physician be non-compliant with timely response, the Medical Director shall be consulted in an effort to serve as a liaison, as needed, to ensure timely physician response. IV. As a</p>	07/29/2015

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	<p>PCP (primary care physician)." There was lack of documentation to indicate a treatment order was obtained or the facility followed up with the Physician.</p> <p>An Initial Pressure Ulcer Assessment for the right upper buttocks was initiated on 6/14/15. The assessment indicated a stage II pressure ulcer began on the right upper buttocks on 6/14/15. The stage II area measured 2.9 x 1.6 cm, serosanguinous (serous fluid with blood) exudate, no tunneling/undermining, red wound bed and red wound edges. The assessment indicated the Physician was notified on 6/14/15 via fax and the resident's legal representative was notified.</p> <p>A Physician's Order, dated 6/16/15, indicated treatment orders for the right heel wound, the right outer ankle wound, and the buttocks wound.</p> <p>Review of the June 2015 Treatment Administration Record (TAR) indicated the daily treatments to the right heel wound, the right outer ankle wound, and the buttocks wound were started on 6/17/15 on the afternoon shift.</p> <p>There was lack of documentation in the record to indicate any treatment orders had been obtained prior to 6/16/15 or</p>		<p>means of quality assurance, results of the aforementioned audits and any corrective actions taken shall be reported to the QA Committee during quarterly meetings for a minimum of 6 months and the plan adjusted if indicated through the monitoring forms.</p>	

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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>implemented to the right heel, right outer ankle, and buttocks pressure areas until 6/17/15.</p> <p>Interview with the Regional Director on 6/25/15 at 3:20 p.m. indicated he could see where the stage II to the buttocks on 6/11/14, unstageable to the right ankle on 6/11/15, and stage II to the right upper buttocks on 6/14/15 had been identified and no treatment had been started to those areas prior to 6/17/15. He further indicated the Physician was notified by fax on 6/11/15 with the request for treatment orders with no response. He also indicated the Physician was faxed again on 6/14/15 with no response. He further indicated there had been a delay in treatment and staff should have followed up with the Physician sooner.</p> <p>A policy titled "Notification of Change", dated 10/2014, received from the Administrator as current on 6/25/15 at 3:04 p.m. indicated "...If a response to the faxed notification/information is not received in an acceptable time frame, the physician's office will be contacted per telephone and response requested by the facility in an effort to provide the resident with any potentially needed care/intervention...A physician must not be contacted via fax if the resident is in an emergency situation and/or an</p>			

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F 0465 SS=E Bldg. 00	<p>immediate response is needed..."</p> <p>3.1-22(b)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to sagging and stained ceiling tiles, gouged doors and walls, marred walls, chipped paint, loose and chipped cove base, and rusty faucets on 3 of 4 hallways throughout the facility. (A hall, C hall, D hall). This had the potential to affect the 40 residents residing in the facility.</p> <p>Findings include:</p> <p>An Environmental Tour was conducted on 6/29/15 at 1:40 p.m. with the Administrator, Maintenance Director and Housekeeping Supervisor. The following areas were observed:</p> <p>1. A Hall</p> <p>a. The ceiling in the main hallway outside of the ice machine nook was sagging and</p>	F 0465	<p>The facility failed to maintain a functional and safe environment related to sagging and stained ceiling tiles, gouged doors and walls, marred walls, chipped paint, loose and chipped cove base, and rusty faucets on 3 of 4 hallways throughout the facility. (A hall, C hall, D hall). 1. A Hall a. Ceiling tiles in the main hallway outside the ice machine were replaced. b. Room 1 wall repairs and painting were completed , covebase was secured. c. Room 3 room and bathroom wall and door repairs and painting were completed. d. Room 6 room and bathroom wall and door repairs and painting were completed. 2. C Hall a. Hallway walls were repaired. b. Room 3 wall and bathroom walls were repaired and painting completed. Faucet will be freed of corrosion or replaced, if warranted. c. Room 5 Headboard replaced and bathroom sink thoroughly cleaned. d. Room 6 room and bathroom walls repaired and painting completed.</p>	07/29/2015

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	<p>appeared to have a large circular stain.</p> <p>b. Room 1: The bathroom walls around and below the soap dispenser were gouged, the cove base in the bathroom by the door was loose, and the wall by the window bed was gouged. Two residents resided in this room.</p> <p>c. Room 3: The walls above and next to the bed by the door were gouged, the bathroom walls around the soap dispenser were gouged and unpainted, and the inner bathroom door was gouged. Two residents resided in this room.</p> <p>d. Room 6: There were holes in the walls above both beds and the bathroom wall was marred and unpainted around the soap dispenser. Two residents resided in this room.</p> <p>2. C Hall</p> <p>a. The walls along both sides of the hallway were gouged.</p> <p>b. Room 3: There were black mars and scrapes on the walls by the window bed, a white unpainted area on the wall to the left of the bathroom door, peeled paint to the bathroom walls behind the sink and toilet, and the bathroom faucet appeared white and corroded. Two residents</p>		<p>Window sill cleaned. Faucet will be freed of corrosion or replaced, if warranted. 3. D Hall a. Hallway walls were repaired. b. Room and bathroom walls repaired and painting completed. c. Bathroom walls and door repaired and painting completed. d. Room and bathroom walls repaired and painting completed. Faucet will be freed of corrosion or replaced, if warranted. Bathroom flooring will be thoroughly cleaned and scheduled for replacement, if warranted. e. Bathroom door repaired. f. Bathroom wall repaired and painting completed. g. Bathroom door and wall repaired and painting completed. II. Facility wide rounds will be conducted and all areas in need of repair identified and a schedule of scheduled repairs completed. Thereafter, at least, monthly facility wide rounds shall be completed and the schedule updated and/or expanded with any newly identified concerns. III. As a means to ensure ongoing compliance, the Administrator shall be responsible to meet with the Maintenance Director on a twice weekly basis to confirm compliance with the completion of necessary repairs. The Administrator shall be responsible to inspect completed repairs to confirm completion. IV. As a means of quality assurance, the Administrator shall be responsible to report to the QA Committee on a quarterly basis results of</p>	

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	<p>resided in this room.</p> <p>c. Room 5: The headboard on the bed by the door was chipped and there was a significant rust colored stain in the bathroom sink. One resident resided in this room.</p> <p>d. Room 6: The walls next to the bed by the door were marred and gouged, the window sill was covered with a gummy substance, the paint on the bathroom wall behind the toilet was bubbled and peeling, and the bathroom faucet appeared white and corroded. Two residents resided in this room.</p> <p>3. D Hall</p> <p>a. The walls along both sides of the hallway were gouged.</p> <p>b. Room 2: The walls next to the bed by the door were marred and gouged, the wallpaper was peeling from the wall next to the window bed, and the bathroom wall was gouged and unpainted around the soap dispenser. Two residents resided in this room.</p> <p>c. Room 3: The inside of the bathroom door was gouged and the bathroom wall around the soap dispenser was gouged and unpainted. One resident resided in</p>		<p>aforementioned rounds and compliance with repair schedule. Frequency of monitoring shall be increased or decreased on the basis of rounds and compliance observations.</p>				

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	<p>this room.</p> <p>d. Room 4: The walls were gouged and marred throughout the room, several areas were patched and left unpainted, the cove base in the room had chipped and missing areas, the bathroom walls were gouged, the bathroom cove base had sections missing, the bathroom faucet appeared white and corroded, and the floor around the toilet appeared "rust-stained." One resident resided in this room.</p> <p>e. Room 5: The inner bottom of the bathroom door was gouged. One resident resided in this room.</p> <p>f. Room 6: The bathroom wall around the soap dispenser was gouged and unpainted. One resident resided in this room.</p> <p>g. Room 7: The inner bathroom door was gouged and the bathroom wall around the soap dispenser was gouged and unpainted. Two residents resided in this room.</p> <p>Interview with the Administrator at the time of the tour, indicated all of the areas were in need of repair.</p> <p>3.1-19(f)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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