

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2014
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NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>November 12, 13, 14, 17, 18, 19, 20, and 21, 2014</p> <p>Facility number :001149 Provider number : 155618 AIM number : 200145500</p> <p>Survey team : Michelle Hosteter, RN-TC Gloria Bond, RN Sandie Nolder, RN</p> <p>Census bed type: SNF: 33 SNF/NF : 28 Residential : 87 Total : 148</p> <p>Census payor type : Medicare :13 Medicaid : 28 Other : 20 Total : 61</p> <p>Residential Sample : 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p>	F000000	<p>The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</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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F000164 SS=D	<p>Quality Review was completed by Tammy Alley RN on December 2, 2014.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure a CNA provided privacy during ADL (Activities of Daily Living) care for 1 of</p>	F000164	F164 Personal Privacy It is the practice of this facility to comply with F164 Personal Privacy <u>What corrective actions(s) will be accomplished</u>	12/18/2014
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	<p>1 resident's reviewed for privacy. (Resident #10)</p> <p>Findings include:</p> <p>Resident #10's record was reviewed on 11/20/14 at 11:30 a.m. Diagnoses included, but were not limited to, obesity, depressive disorder, and bipolar disorder.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 8/27/14, indicated: The resident's BIMS (Brief Interview for Mental Status) was 15, which meant she was cognitively intact. The resident required extensive assist for dressing and personal hygiene.</p> <p>On 11/18/14 at 11:01 a.m., the resident was observed with her sweatshirt above her breasts making her breasts visible and her perineum area was covered with a small towel. The resident did not have a blanket or sheet covering her. The resident's call light was observed on upon entering the resident's room. LPN # 3 was observed pulling the resident's sweatshirt down to cover the resident's breasts. The resident indicated at that time there had been a CNA in her room helping her get dressed, then the CNA left her room and she never came back, so she turned on her light to get some assistance. LPN # 3 indicated at that</p>		<p><u>for those residents found to have been affected by the deficient practice?</u> Resident 10 is receiving personal care in a private setting to ensure privacy and dignity is maintained. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u> _ Residents who reside in this facility have the potential to be affected by this alleged finding. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> _ Licensed Nurses and Certified Nursing Assistants will be educated on privacy during personal care. Nursing staff who fail to comply with expectation of privacy during personal will be educated and/or progressively disciplined as indicated. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u> _ Administrative Director of Nursing/ designee will conduct random rounds, across variety of shifts, 5 days a week for three weeks to ensure that each resident receives personal care delivered in a private environment; monitoring will continue weekly thereafter for 4</p>				

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F000241 SS=D	<p>time "A CNA was just in here assisting her to get up for lunch." LPN # 3 left the room to get a CNA to assist the resident.</p> <p>On 11/18/14 at 11:08 a.m., LPN # 3 and the Director of Care Delivery (DCD) for the second floor had come to the room and the DCD covered the resident with a bath blanket.</p> <p>During an interview on 11/18/14 at 4:00 p.m., the DCD of the second floor indicated Resident # 10 should have been covered up with a blanket while she was waiting on the CNA to come back to assist her.</p> <p>3.1-3(o)(4)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, a resident was not treated in a respectful manner by staff for 1 of 7 residents reviewed for dignity. (Resident # 140)</p> <p>Findings included:</p> <p>On 11/13/14 at 1:03 p.m., Resident #140 indicated, " Sometimes staff treat me</p>	F000241	<p>additional weeks. Any staff member found to be in non-compliance with these resident rights expectation will be addressed immediately. Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>F241 It is the practice of this facility to comply with F241 Dignity and Respect of Individuality <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> _ Resident 140 is being treated in a respectful manner by staff. <u>How other residents having the</u></p>	12/18/2014			

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	<p>with respect and dignity, others rush with care and are only there for a paycheck."</p> <p>During the interview on 11/17/14 at 1:50 p.m., the Nurse Practitioner (NP) came in and told the resident hello and that she needed to talk to him, but she saw he was busy, so she would come back later. The NP then went and talked to the resident's room mate and then left the room. The resident pushed his call light as he was beginning to have cramping and pain in his right leg. The NP came in and assisted the resident in repositioning his leg and started to look at his feet, and he asked what she was doing. She indicated she was just checking his feet. He became upset and told her he said he was busy right now and that she needed to come back. He then paused and indicated to her she could go ahead and get it done. At that point, the NP became visibly irritated and said to the resident, "Oh no, I will come back later." The resident indicated he did not understand what she did not understand about him asking her to come back later. The resident continued the interview, but would become distracted and bring up the interaction with the NP again and indicated how that really bothered him. About 10 minutes later the resident pushed his call light.</p>		<p><u>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u> - Residents who reside in this facility have the potential to be affected by this alleged finding. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> - Nursing staff and practitioners were educated on Resident Rights with emphasis on providing care or services in a manner and environment that maintains dignity. Nursing staff found to be in non-compliance with this resident right will be addressed immediately. Nursing staff who fail to comply with these expectations will be educated and/or progressively disciplined as indicated. Medical Director will be contacted to assist and support with any concerns identified with practices of other physicians or practitioners. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u> - Administrative Director of Nursing/ designee will conduct random rounds, across variety of shifts, 5 days a week for three weeks to validate privacy is maintained for residents; monitoring will continue weekly</p>		

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F000246 SS=D	<p>On 11/13/14 at 2:03 p.m., LPN #1 answered the call light and the resident told her his concern about how the NP treated him when she walked in during the interview. He was visibly upset and indicated to LPN #1 he did not feel he was treated respectfully when he asked her to come back later, and then she just walked out of the room. LPN #1 indicated she would check into it and would get him some pain medication.</p> <p>3.1-3(t)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, and interview, the facility failed to have the cord to the over the bed task light accessible to residents for reading and night time needs for 4 out of 35 residents reviewed for accommodation of needs. (Resident #39, #26, and #7).</p> <p>Findings include:</p> <p>1. During an interview on 11/13/2014 at</p>	F000246	<p>thereafter for 4 additional weeks. Any staff or practitioners found to be in non-compliance with these resident rights expectation will be addressed immediately. Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>F 246 It is the practice of this facility to comply with F 246: Reasonable Accommodation of Needs <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Residents 39, 26, 7 and 11 had their overhead lights inspected by maintenance and repairs completed as necessary. <u>How other residents having the</u></p>	12/18/2014			

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	<p>4:30 p.m., Resident #39 indicated she was unable to turn her over the bed light on and off because she could not reach the light string.</p> <p>On an environmental observation on 11/20/2014 at 11:05 a.m., the resident's over bed light string was observed behind the bed, hanging close to the wall. The nightstand and bedside table were in front of the light string as well.</p> <p>2. During an interview on 11/13/2014 at 11:05 a.m., Resident #26's personal care giver indicated the over the bed light does not have a string on it to turn it on and off and the switch on the one side does not turn it on and off. The care giver indicated this new light was, " just installed."</p> <p>On an environmental observation on 11/20/2014 at 10:50 a.m., the resident's over the bed light was observed with a light switch on one side of the bed that did not turn the light on or off and a 1 to 2 inch chain on the other side that could be pulled to turn the light on and off. There was no string attached to the short chain.</p> <p>3. During an interview on 11/13/2014 at 3:07 p.m., Residents #7 indicated the string on her over the bed light was hard</p>		<p><u>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u> - Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> - Maintenance Director and nursing staff were educated on reporting necessary repairs that are needed to ensure resident needs are accommodated. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u> - Maintenance Director or designee will conduct visual inspections of resident rooms 5 days a week to ensure all rooms are inspected minimally, on a monthly basis to ensure overhead light cords are appropriate length and are accessible to the residents. Monitoring will continue for a total of 3 months. Results of the monitoring will be reviewed for patterns/trends quarterly by Administrator/Maintenance Director. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations quarterly ongoing.</p>		

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F000309	<p>to reach and use when she was in bed.</p> <p>On an environmental observation on 11/20/2014 at 10:55 a.m., the resident's over head light string was observed lying next to the wall and not easily accessible to the resident in bed.</p> <p>4. During an interview on 11/20/2014 at 1:10 p.m., CNA #11 indicated after assisting a resident to bed she would make sure the call light was in reach and the water was by the bed. At 1:15 p.m., CNA #12 indicated after assisting a resident to bed she would make sure the call light was in reach, the water was near the bed, the bed was at the proper height according to their care plan and would ask if the resident needed anything else.</p> <p>During an interview with the ADCD (Assistant Director of Clinical Delivery Services) on 11/20/2014 at 2:35 p.m., she indicated she would expect the CNAs to make sure the call light was in reach before they left a resident's room but she had not been aware that there was a concern with the string to the over the bed light being un-accessible to the residents.</p> <p>3.1-3(v)(1)</p>						
	483.25						

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SS=D	<p>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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, interview and record review, the facility failed to provide relief for a resident's pain for 1 of 3 resident's reviewed for pain management. (Resident #60)</p> <p>Findings include:</p> <p>Resident #60's record was reviewed on 11/17/14 at 9:36 a.m. Diagnoses included, but were not limited to, debility, chronic pain syndrome, headache, otalgia (ear pain), restless leg syndrome, arthritis and difficulty in walking.</p> <p>During an interview on 11/12/14 at 1:36 p.m., the resident indicated she always had a headache. She indicated her headache went from her left side of her head down her head into her left ear and the left side of her neck. She indicated her headaches were unbearable at times. She indicated the pain medication eased the headaches, but it did not relieve the pain completely.</p>	F000309	<p>F309 It is the practice of this facility to comply with F309: Provide care/Services for Highest Well Being What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #60 was reassessed, to identify the source of actual, potential, and anticipated pain. Based on the results of the assessment, physician was notified and medication review completed to ensure that medications were appropriate. New orders processed accordingly. Care plan revised and Kardex updated to include non-pharmacological approaches to assist in pain management. R60 placed on pain tracking to monitor effectiveness of interventions and reviewed as needed to achieve desired outcomes. 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>Residents who report unrelieved pain have the potential to be affected by this alleged finding.</p>	12/18/2014			

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	<p>On 11/12/14 at 1:46 p.m., the resident was observed holding the left side of her head, rubbing the area of her head from the top of the left side of her head down the left side of her head and ear into the left side of her neck. She was observed to have facial grimacing. At that time the resident was complaining she had a headache with pain that went into her neck.</p> <p>The resident's MAR's (Medication Administration Record) dated September, October and November 2014, were reviewed and included, but were not limited to the following orders: 5/22/14-Tylenol (Acetaminophen) tablet (over the counter pain medication) 325 mg (milligrams) Give one tablet by mouth every four hours as needed for pain or fever. Do not exceed 4000 mg from all sources of Tylenol in 24 hours. 5/23/14-Pain Evaluation every shift. 7/08/14-Tramadol HCL (narcotic pain medication) 50 mg Give one tablet by mouth every six hours for pain. 7/23/14-Excedrin Migraine tablet (over the counter migraine headache medication) 250-250-65 mg (Aspirin-Acetaminophen-Caffeine) Give one tablet by mouth as needed for headache. 9/09/14-Voltaren Gel (an anti-inflammatory medication) Apply to</p>		<p>A thirty day look back, utilizing an audit tool, was completed to identify resident with a pain score of four to seven twice in a seven day period or a score of eight, nine or ten at a single time was reviewed to validate completion of the pain assessment, and the efficacy of the med regimen. Discrepancies initiated a new pain evaluation and assessment if found. Care plans and Kardex were reviewed for accuracy. Identified residents were placed on the pain tracking to further monitor daily during morning IDT meeting. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Licensed nurses and Certified aides were re-educated on Pain Management Guidelines. Administrative Director of Nursing and Direct Care Delivery staff were re-educated on the pain tracking system to be utilized to allow for identification of unmanaged or unrelieved pain. New or existing patients identified with pain exceeding pain goal or those experiencing unrelieved pain will be added to the daily pain tracking tool and will be reviewed daily by the IDT during morning meeting to determine appropriate approaches, assessments, or interventions necessary to meet each resident's pain goal in accordance with center's pain</p>				

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	<p>bilateral shoulders topically twice daily for pain.</p> <p>10/30/14-Tizandine HCL (a muscle relaxant medication) tablet 4 mg Give 1 tablet by mouth three times daily for muscle spasm for 14 days, then every eight hours as needed for muscle spasms.</p> <p>The resident's MDS (Minimum Data Set) assessment dated 9/4/14, indicated her BIMS (Brief Interview for Mental Status) was a 15, which indicated she was cognitively intact.</p> <p>A pain evaluation dated 8/16/14 at 12:25 p.m., indicated the resident's pain was located in her head and neck.</p> <p>A pain scale level of 0 meant no pain and a pain scale level of 10 meant the worst pain.</p> <p>The resident's pain evaluation for every shift for September 2014, indicated the following: The resident's pain level was a level 4 or higher 17 out of the 33 times she complained of pain and she had 3 weeks when she complained her pain was greater than level 4 more than once that week .</p> <p>The resident's pain evaluation for every shift for October 2014, indicated the</p>		<p>guidelines. Licensed nurses and Certified aides who fail to comply with expectation of their role in Pain Management Protocol will be educated and/or progressively disciplined as indicated. How will the corrective actions be monitored to ensure they do not occur again? Administrative Director of Nursing or designees will monitor pain scores daily. Based on findings, audit tool will be completed to validate compliance is sustained and submitted to the QAA committee. Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p>		

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	<p>following:</p> <p>The resident's pain level was a level 4 or higher 7 out of the 17 times she complained of pain and one pain level was reported as a level 10.</p> <p>The resident's pain evaluation for every shift from November 1-17, 2014, indicated the following: The resident's pain level was a level 4 or higher 5 out of the 11 times she complained of pain. One week the resident's pain level was reported greater than a level 4 more than twice in that week, with one of those pain levels being rated at a level 8.</p> <p>The resident's pain evaluation for September 2014, October 2014 and November 2014 had not indicated the location of the resident's pain or the pain level of the pain after the resident was medicated with as needed (PRN) pain medications.</p> <p>The resident's PRN pain medications for September 2014, October 2014 and November 2014, were reviewed and she had received the following doses of PRN medications:</p> <p>During September 2014, the resident had received one Excedrin Migraine one tablet for pain 14 times. Tylenol one</p>				

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	<p>tablet for pain 2 times.</p> <p>During October 2014, the resident had received Excedrin Migraine one tablet for pain 2 times. Tylenol one tablet for pain 1 time.</p> <p>During November 1-17, 2014, the resident had received Excedrin Migraine one tablet for pain 3 times. Tylenol one tablet for pain 2 times. Tizanidine HCL one tablet for muscle spasms 1 time.</p> <p>During an interview on 11/17/14 at 10:25 a.m., LPN # 3 indicated the resident complained of a headache that went to her left side of her head down into her neck and into her shoulders and across her shoulders. She indicated she usually complained of the headache right before lunch when it was time to receive her routine Tramadol. LPN # 3 indicated at times the routine Tramadol helped the resident's pain. She indicated when the routine Tramadol did not help her pain she would give her the PRN Excedrin Migraine and it was usually effective. She indicated a couple of weeks ago the doctor told the resident she was not going to prescribe any stronger medication for her headache and Tizanidine was ordered for muscle spasms to try to relieve her headaches. She indicated the resident had a head injury prior to her admission to the</p>			
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	<p>facility and that was the cause of her headaches.</p> <p>During an interview on 11/18/14 at 4:23 p.m., the DNS (Director of Nursing Services) indicated pain was what the resident said it was and if the resident had pain and there was PRN medications available, then she should have been medicated for pain. She indicated she would have liked to have seen documentation on the MAR or in the progress notes of what kind of pain the resident was experiencing when the nurses assessed her pain. She indicated she would liked to have known if the nurses went back in 15-20 minutes after the routine Tramadol was given to reassess the resident's pain to see if it was better when she complained of pain at the time when her Tramadol was due. She indicated if the resident had PRN pain medication available that could be given, she would have given it to her when she complained of pain.</p> <p>A current policy titled "Pain Practice Guide" dated 11/2011, was provided by the Administrator on 11/19/14 at 2:30 p.m., indicated "...Purpose: The purpose of the Pain Practice Guide is to describe the process steps for techniques and interventions to prevent and, or manage pain both chronic and acute...Numeric</p>			

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F000312	<p>Pain Rating: The Numeric Pain Rating Scale is used for alert and oriented patients. In using the numeric rating scale, the patient is asked to identify how much pain they are having by choosing a number from 0 (no pain) to 10 (the worst pain imaginable)... Medical Care Initiative... pain evaluation is also completed before and after PRN pain medication administration. The patient's pain scale and score is recorded on the Medication Administration Record (MAR)... Pain Prevention And Reduction... Results are documented on the Medication Administration Record (MAR) following each observation. Patients with a score of 4 to 7 twice in a 7 day period or who had one score of 8, 9, 10 are reported to the physician for possible treatment adjustment, noted on 24-Hour Report, reviewed during the Eagle Room process and monitored on the Eagle Room Process Observation Tools: Pain and Pain Management. FYI... "Rule of 3's" If a patient requires break through medication more than three times in 24 hour period or at least once for three successive days, the patients scheduled pain medication may need to be adjusted...."</p> <p>3.1-37(a) 483.25(a)(3)</p>			

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SS=D	<p>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to provide showers as scheduled to 2 of 3 residents being reviewed for ADL's (Activities of Daily Living), cleanliness and grooming. (Resident #63 and #106)</p> <p>Findings include:</p> <p>1. Resident #63's record was reviewed on 11/17/14 at 5:14 p.m. Diagnoses included, but were not limited to muscle weakness, depressive disorder, difficulty in walking, abnormal posture, malaise and fatigue symptoms.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 11/6/14, indicated the functional status for the resident's bathing was total dependence and one person physical assist.</p> <p>An untitled current document dated 11/17/14, provided by the MDS (Minimum Data Set) Coordinator on 11/17/14 at 5:30 p.m., indicated the resident's shower/bath schedule was on</p>	F000312	<p>F312 It is the practice of this facility to comply with F312 ADL Care Provided for Dependent Residents <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident 63 and 106 were re-interviewed to confirm that the scheduled shower days were accurate, based on preference. As a result of those interviews, clinical record was updated to reflect the desired shower days and system revised to allow for documentation of completed showers. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u> Dependent residents who reside in this facility have the potential to be affected by this alleged finding. Center reviewed clinical records of existing patients to ensure that all residents had their preferences related to bathing clearly indicated in their plan of care and CNA task list reflected consistent information regarding those preferences. <u>What measures will be put into place or what</u></p>	12/18/2014
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	<p>Wednesdays and Saturdays on dayshift.</p> <p>The "Documentation Survey Report" for Tasks Only dated September 2014, provided by the MDS Coordinator on 11/17/14 at 5:30 p.m., indicated: The resident was to receive her shower/bath on Wednesdays and Saturdays on day shift. The resident received two showers. The resident received three bed baths. There was documentation the resident refused two showers. There was documentation the resident was not available one day for a shower.</p> <p>The "Documentation Survey Report" for Tasks Only dated October 2014, provided by the MDS Coordinator on 11/17/14 at 5:30 p.m., indicated: The resident was to receive her shower/bath on Wednesdays and Saturdays on day shift. The resident received seven showers. There was documentation the resident refused two showers.</p> <p>The "Documentation Survey Report" for Tasks Only dated November 2014, provided by the MDS Coordinator on 11/17/14 at 5:30 p.m., indicated: The resident was to receive her shower/bath on Wednesdays and Saturdays on day shift.</p>		<p><u>systemic changes will be made to ensure that the deficient practice does not recur?</u> - CNA's were re-educated on bathing policies and corresponding documentation, including accuracy of the information submitted. Administrative Director of Nursing or designee will review documentation for new admissions to ensure that preferences were obtained and that care plan/Kardex reflects these choices. Administrative Director of Nursing or designee will review bath schedules 5 days a week x 4 weeks and then random audits weekly for 3 months to validate that showers are received on designated days and that documentation has been submitted electronically to reflect completion; those who have refused will be offered an alternative day/time. Nursing staff who fail to comply with these facility guidelines will be educated and/or progressively disciplined as indicated. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u> - Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until</p>		

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	<p>The resident received four showers. There was documentation the resident refused one shower.</p> <p>The resident did not have a Care Plan that addressed she refused care, treatments or showers.</p> <p>During an interview on 11/13/14 at 5:04 p.m., the resident indicated she may have gotten one or two showers a week. She indicated she wanted two showers a week. She indicated she had not refused her showers.</p> <p>During an interview on 11/13/14 at 5:04 p.m., a family member indicated on Saturdays, when the facility was short of staff, his family member did not get her showers.</p> <p>During an interview on 11/18/14 at 3:06 p.m., the DCD (Director of Care Delivery) of the second floor indicated the sheet that was provided on 11/17/14 at 5:30 p.m., by the MDS Coordinator with the resident's ADL information was the information the CNA's followed in the computer to provide showers for the resident.</p> <p>During an interview on 11/18/14 at 5:18 p.m., the DCD of the second floor indicated the resident would not have</p>		<p>compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p>				

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	<p>refused her showers.</p> <p>2. Resident # 106's record was reviewed on 11/18/14 at 5:10 p.m. Diagnoses included, but were not limited to, depressive disorder, cerebrovascular artery occlusion with infarction, hemiplegia, aphasia, dysarthria, abnormal posture symptom and diabetes mellitus.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 8/13/14, indicated the functional status for the resident's bathing was total dependence and one person physical assist.</p> <p>An untitled current document dated 11/17/14, provided by the MDS (Minimum Data Set) Coordinator on 11/17/14 at 5:30 p.m., indicated the resident's shower/bath schedule was on Mondays, Thursdays and Saturdays.</p> <p>The "Documentation Survey Report" for Tasks Only dated September 2014, provided by the MDS Coordinator on 11/17/14 at 5:30 p.m., indicated: The resident was to receive her shower/bath on Mondays, Thursdays and Saturdays on day shift. The resident received seven showers. The resident received two bed baths. The document had four boxes with an "X" marked in them that were Saturdays.</p>			

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	<p>The "Documentation Survey Report" for Tasks Only dated October 2014, provided by the MDS Coordinator on 11/17/14 at 5:30 p.m., indicated: The resident was to receive her shower/bath on Mondays, Thursdays and Saturdays on day shift. The resident received seven showers. The resident received one bed bath. There was documentation the resident refused her shower one time. The document had four boxes with an "X" marked in them that were Saturdays.</p> <p>The "Documentation Survey Report" for Tasks Only dated November 2014, provided by the MDS Coordinator on 11/17/14 at 5:30 p.m., indicated: The resident was to receive her shower/bath on Mondays, Thursdays and Saturdays on day shift. The resident received four showers. The resident received one bed bath. The document had four boxes with an "X" marked in them that were Saturdays.</p> <p>The resident did not have a Care Plan that addressed she refused care, treatments or showers.</p> <p>A "Concern Form" dated 5/2/14, indicated the resident had a concern that she did not get to choose the number of</p>			

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	<p>showers she received a week. She requested on 5/7/14 to add a third shower a week. The form indicated the resolution for the concern was the resident was placed on the shower list for 3 showers a week on Mondays, Wednesdays and Fridays.</p> <p>The "Second Floor 6AM-2PM Shift Showers" document dated 11/18/14, provided by the DCD of the second floor at 5:12 p.m., indicated this resident's shower days were listed on this document as Mondays and Thursdays.</p> <p>During an interview on 11/13/14 at 1:34 p.m., the resident indicated her showers were scheduled on Mondays and Thursdays on the day shift. She indicated she had told a staff member she wanted three showers a week and her showers were increased to Mondays, Wednesdays and Fridays, then her showers were decreased back down to two showers a week on Mondays and Thursdays. She indicated she wanted three showers a week. She indicated she had not refused her showers.</p> <p>During an interview on 11/18/14 at 3:06 p.m., the DCD (Director of Care Delivery) of the second floor indicated the sheet that was provided on 11/17/14 at 5:30 p.m., by the MDS Coordinator</p>			

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	<p>with the resident's ADL information was the information the CNA's followed in the computer to provide showers for the resident. The DCD of the second floor indicated Resident # 106's September, October and November Shower documentation indicated she had not received her showers on Mondays, Thursdays and Saturdays as scheduled. She indicated the resident was not able to independently shower.</p> <p>During an interview on 11/18/14 at 5:12 p.m., the DCD of the second floor indicated Resident # 106 had made a concern while on the first floor in May regarding she wanted three showers a week and her showers were getting done three times a week after that concern on the first floor. She indicated the resident was moved to the second floor and when her showers were placed into the computer system for the CNA's to view, there was a "glitch in the system, so the Saturday shower was not showing up in the computer." The DCD of the second floor indicated since the Saturday showers were not scheduled in the computer system or on the second floor shower assignment sheet, her showers were not being completed three times a week upstairs. She indicated she had not known of a time the resident had refused her showers.</p>			

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F000323 SS=D	<p>3.1-38(a)(3)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a safe transfer method was provided to prevent a potential accident hazard (Resident #10 and #99) and failed to ensure fall prevention interventions were in place (Resident #99) for 2 of 4 residents reviewed for accidents in sample of 4.</p> <p>Findings include:</p> <p>1. Resident #10's record was reviewed on 11/20/14 at 11:30 a.m. Diagnoses included, but were not limited to, muscle weakness, difficulty in walking, bipolar disorder, depressive disorder, obesity, osteoarthritis, and abnormal posture symptom.</p> <p>On 11/18/14 at 11:54 a.m., a transfer was observed with two CNA's. CNA #6 and CNA # 7 was observed attempting to transfer Resident #10 with a mechanical lift from the bed to an electric</p>	F000323	<p>F 323 It is the practice of this facility to comply with F 323 Free of Accident Hazards/Supervision/Devices <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident 10 has been re-evaluated for transfer status. As a result of that assessment, care plan and CNA task list has been reviewed and revised as needed. Resident 99's care plan was reviewed to validate that listed interventions were current and appropriate. Modifications and updates completed as necessary. Visual observations were completed to ensure that all fall prevention interventions were in place; identified concerns were corrected. CNA's were provided a gait belt and review of dress code policy was completed, which included gait belt as part of uniform. Gait belts were also made available for nurses. CNA's 6, 7, 8, LPN 3, and second floor DCD were provided 1:1</p>	12/18/2014	

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	<p>wheelchair. The resident was in a mechanical lift sling and was being transferred with the mechanical lift by CNA #6 from the bed to the wheelchair, while CNA #7 was standing on the opposite side of the bed. CNA # 7 removed the resident's bed linens while CNA #6 was moving the mechanical lift away from the bed. CNA # 7 was coming around the foot of the bed while the resident was swinging in the air in a slow motion while she was being moved with the lift from the bed to the electric wheelchair. CNA #6 had difficulty moving the mechanical lift and guiding it over to the electric wheelchair, then she had difficulty getting the legs of the lift open and the right leg of the lift was caught under the electric wheelchair. During the transfer to the electric wheelchair with the mechanical lift, no staff member was supporting the resident's feet or head or holding onto the sling.</p> <p>LPN # 3 instructed CNA # 6 to turn the mechanical lift at an angle to get the resident into a position to line her up with the seat of the electric wheelchair. CNA # 7 was attempting to pull the resident back into the electric wheelchair seat when the resident complained her feet were hitting the mechanical lift bar. At that time, LPN # 3 was able to assist with</p>		<p>education regarding transfers and conducted a return demonstration to validate skill. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u> _ 1. Residents who require 2 person physical assist with transfers have the potential to be affected by the alleged finding. Identified patients were re-evaluated for transfer status. As a result of those assessments, care plan and task list were reviewed and revised to ensure accuracy to plan of care. Any concerns were corrected. 2. Residents who have had repeat falls in past 12 months have the potential to be affected by the alleged finding. Identified patient's plan of care was reviewed to ensure that fall interventions were current and appropriate. Inspections completed to ensure that fall interventions were in place and corresponded with plan of care. Any identified concerns were corrected. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> _ Nursing staff were re-educated on the Transfer policies, including use of mechanical lifts and gait belt, and fall guidelines. New residents or those who have had a significant change will be</p>				

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	<p>the transfer since she had finished administering medication to the resident's roommate. LPN # 3 and CNA # 7 each grabbed a side of the mechanical sling and tried to pull the sling back to bring the resident into position with the electric wheelchair seat, but was unable to position her appropriately. The resident yelled "My feet hurt, watch my feet." The resident's feet was hitting the front of the mechanical lift bar. The back of the electric wheelchair seat was sitting up against the residents' closet doors, so no staff member could get behind the seat and pull her into the seat into a proper alignment.</p> <p>LPN # 3 left the room to get more help for the transfer, while the resident was in the mechanical lift sling in the air with CNA # 6 and CNA #7 in the room with her.</p> <p>CNA # 8 came into the room to assist with the transfer. She and CNA # 7 were on each side of the resident and LPN # 3 was to the left side of the electric wheelchair seat trying to reach over the back of the seat to pull the resident into the seat from the back, while the CNA's pulled her into the seat from the sides. The resident was partially sitting on the electric wheelchair seat. At that time, the resident indicated, "I am going to be sick, I am going to be sick." The staff indicated</p>		<p>reviewed to validate that assessments are completed for transfer status and that plan of care/task list has been developed to reflect individual needs. Residents who have experienced fall will be reviewed by the IDT to determine appropriate interventions necessary to minimize or eliminate identified risks. Inspections will be completed to validate that the assigned interventions have been implemented. Facility staff who fail to comply with these facility guidelines will be educated and/or progressively disciplined as indicated. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u> Administrative Director of Nursing or designee will conduct observations 3 times a week x 4 weeks and then weekly thereafter x 3 months to validate transfers are conducted in accordance with plan or care, as well as in conjunction with policies. Administrative Director of Nursing or designee will conduct audits following falls 5 days a week x 4 weeks and then randomly thereafter for 3 months to validate that fall interventions are in place per plan of care. Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be</p>				

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	<p>they were not going to be able to get Resident #10 in the electric wheelchair, so they were placing her back into her bed. The resident was transferred back to bed with the mechanical lift by CNA #6, while the sling swung slowly in the air. No staff members was supporting the residents head or feet or holding onto the sling. CNA # 8 instructed CNA # 6 to open the legs of the lift as she moved the lift towards the bed as she placed the legs of the lift under the bed.</p> <p>On 11/18/14 at 12:32 p.m., CNA # 6, CNA # 7 and CNA # 8 was observed bringing the mechanical lift back to Resident #10's room to get her up for lunch and she refused to get up for lunch. She indicated she was not getting up using the mechanical lift.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 8/27/14, indicated the resident's BIMS (Brief Interview for Mental Status) was 15, which was cognitively intact.</p> <p>The resident's weight on 11/13/14 was 408 pounds.</p> <p>On 11/18/14 at 4:00 p.m., an assessment for the use of the mechanical lift for Resident #10 was Requested from the second floor DCD (Director of Care</p>		<p>addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p>				

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	<p>Delivery).</p> <p>On 11/19/14 at 10:00 a.m., an assessment for the use of the mechanical lift for Resident #10 was Requested from the DNS (Director of Nursing Services).</p> <p>On 11/20/14 at 9:20 a.m., an assessment for the use of the mechanical lift for Resident #10 was Requested from the DNS (Director of Nursing Services).</p> <p>The resident's LIPS (Lift Injury Prevention System Assessment) dated 2/26/14 indicated she was a 7. "If Total Score is 10-13, Marisa/Tempo/Maxi Move" "If Total Score is 5-9, Chorus/Encore/Sara3000/Sara Plus" "If Total Score is 0-4, Independent"</p> <p>During an interview on 11/18/14 at 12:10 p.m., LPN # 3 indicated there should have been at least three staff members at the beginning of the transfer with the mechanical lift of Resident #10 due to the resident's weight. She indicated the resident weight was 408 pounds. She indicated therapy had assessed her and indicated the resident was unable to use the standup lift anymore due to her legs were weak. She indicated the resident was unable to stand to bear weight and the mechanical lift was the safest way to</p>			

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	<p>transfer her.</p> <p>On 11/18/2014 4:00 p.m., DCD on the second floor indicated the CNA's should have spotted the resident by holding onto the sling while the resident was being transferred. She indicated there should have been more than two staff members to transfer her with a mechanical lift.</p> <p>During an interview on 11/18/2014 5:24 p.m., the DNS indicated the resident did not want to get up in the mechanical lift now because she was more anxious of the lift now than what she had been before the transfer earlier.</p> <p>During an interview on 11/19/14 at 5:30 p.m., Resident #10 indicated she was transferred today with the mechanical lift into a large wheelchair and the transfer went "very well." She indicated she was "a little scared yesterday during all that while they were trying to get me up, but today was much better."</p> <p>During an interview on 11/20/14 at 11:15 a.m., the DNS indicated the PT (Physical Therapy) Manager indicated PT did not assess the resident and indicate it was safe for her to be transferred with the mechanical lift. He indicated that PT just recommended a transfer method.</p>						

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	<p>During an interview on 11/20/14 at 3:39 p.m., the PT Manager indicated Nursing is responsible to assess the resident and decide what type of transfer method to use to transfer the resident. He indicated that upon admission, readmission and a significant change of condition the nursing staff were suppose to do a LIPS (Lift Injury Prevention System) assessment. This assessment had points, which were added and those points were used to determine what type of lift was safe for the resident to use to be transferred. He indicated on occasion the nursing staff would ask the PT department their opinion on what type of transfer method or type of lift they thought was best for a resident. The PT Manager indicated the PT department would recommend a lift or a transfer method, but they were not assessed by the PT department. He indicated the resident after her last hospitalization on 11/13/14, was re-admitted on the therapy case load as a total dependence for all transfers, so that might have been why the PT department indicated she was a mechanical lift transfer. He indicated she should have had a new LIPS assessment by the nursing staff when she returned from the hospital to determine her transfer and lift method.</p> <p>During an interview on 11/21/14 at 8:20</p>			

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	<p>a.m., the DCD on 1st floor indicated the resident's last LIPS assessment was her original admission.</p> <p>2. Resident # 99's record was reviewed on 11/20/14 at 1:13 p.m. Diagnoses included, but were not limited to, difficulty in walking, muscle weakness, aftercare heal trauma fx (fracture) hip, bone/cartilage disorder, muscle spasm, and dementia unspecified without behavioral disturbance.</p> <p>On 11/17/14 at 11:18 a.m., LPN # 3 and the DCD (Director of Care Delivery) of the second floor were observed picking Resident #99 up off the floor in the common area after a fall. LPN # 3 and the DCD of the second floor was observed placing an arm under each one of the resident's arms and legs and lifted her off the floor and placed in her wheelchair. There was no gait belt observed on the resident during the transfer off the floor.</p> <p>On 11/20/14 at 3:20 p.m., the resident was observed being stood up with a gait belt by the DCD of the first floor and RN # 10 and there was no cushion or dycem in the seat of her wheelchair.</p> <p>The resident had a Care Plan dated 8/15/14, that addressed the problem the</p>						

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	<p>resident was at risk for falls related to unsteady gait, history of falls, muscle weakness, difficulty walking, old fx of hip, anorexia.</p> <p>The interventions/tasks indicated, "...1/10/14-Apply dycem under cusion [sic] to help resident from sliding..."</p> <p>The resident's annual MDS (Minimum Data Set) assessment dated 9/19/14, indicated her Cognitive Skills for Daily Decision Making was severely impaired. The resident's functional status for transfers was extensive assist with a two person physical assist.</p> <p>The resident's number of falls had been reviewed from April 2014 to November 17, 2014 and she had the following falls from her wheelchair:</p> <p>On 4/24/14 at 8:00 a.m., "Summoned by CNA to hallway. Observed resident on floor in front of her w/c [wheelchair]. CNA reports she was pushing resident down hallway when resident took feet off foot pedals and place on floor during transit causing her to fall forward onto knees...."</p> <p>On 6/4/14 at 11:30 a.m., "During activities resident slid out of w/c [wheelchair] onto the floor on her</p>			

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	<p>buttocks/witnessed...."</p> <p>On 6/12/14 at 12:45 p.m., "Summoned to room per staff. Resident is on buttocks on floor in front of w/c [wheelchair]...."</p> <p>On 7/24/14 at 1:30 p.m., "Resident sitting in common room attempted to stand slipped out of chair. hit back of head on wc [wheelchair]. no injury noted...."</p> <p>On 7/26/14 at 6:45 p.m., "Resident fall trying to stand by self. Resident had moved self over near chair in lobby area, then proceeded to try and pull up into standing position. Writer was walking around corner when resident attempted to stand. Writer attempted to get to resident and scoot back in chair as resident managed to slide to edge of wheelchair and slide to the floor onto right side... No injury noted...."</p> <p>On 11/7/14 at 7:00 p.m., "Observed resident sliding out of w/c [wheelchair] in lobby in front of nurses station. Unable to get to resident before she fell onto buttocks.... No new bruising observed...."</p> <p>On 11/17/14 at 1:08 p.m., "resident was sitting in lounge area for activities. Activity staff came to nurse desk and stated the resident was on the floor.</p>				

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	<p>Resident was w [with] /out injury and assisted back in wheelchair...."</p> <p>During an interview on 11/18/14 at 4:00 p.m., the DCD of the second floor indicated she and LPN # 3 should have used a gait belt to lift Resident #99 into her wheelchair off the floor instead of placing an arm under each one of her arms and legs. She indicated the residents had the gait belts in their rooms, but the staff members did not have gait belts with them if a resident fell. The DCD of the second floor indicated she had told LPN # 3 to get a gait belt before they lifted her off the floor. LPN # 3 had went into the Nurses' station and looked for a gait belt, but was unable to find one, so she and the DCD of the second floor lifted Resident #99 without the gait belt to get her off the floor.</p> <p>During an interview on 11/20/14 at 3:30 p.m., the DNS (Director of Nursing Services) indicated the resident should have had dycem and cushion on her wheelchair seat.</p> <p>A current policy titled "Gait Belt dated 12/2009, provided by the DCD of the second floor on 11/19/14 at 5:30 p.m., indicated "Purpose: To safely and effectively transfer or ambulate a patient...Procedure:... 6. Place gait belt</p>			

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	<p>around waist. Do not place the belt below the patients waist or around his chest. 7. Secure belt by threading end through buckle. Tuck any excess strap under the belt at the patient's side. 8. Adjust belt to snug fit... 10. Grip belt at patient's sides by placing hands upward under belt, palms facing away from patient..."</p> <p>A current document titled "Tenor Operating and Product Care instructions" (mechanical lift) dated 12/2004, provided by the Administrator on 11/19/14 at 11:56 a.m., indicated "...Safety Instructions... Warning: The risks associated with any transfer of a patient should be fully analyzed before that transfer is carried out... Using your Tenor... Before transportation, turn the patient to face the attendant and lower individual to approximately normal chair height. This gives confidence and dignity and also improves the Tenor mobility... Warning: When lowering the patient back into a chair-or when transferring from bed to chair, ensure the patient is positioned in such a way so he or she is fully supported by the chair when he or she is lowered... At all times when lifting and lowering, it is advisable to stay at the side of the patient to ensure they are in a comfortable position, this is also reassuring for the patient...The patient</p>			

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F000329 SS=D	<p>should be positioned facing the attendant and at a dignified height...."</p> <p>A current policy titled "Mechanical Lift" dated 03/2010 and revised 01/2014, provided by the DCD of the second floor on 11/18/14 at 5:10 p.m., indicated "Purpose: To move immobile or obese patients for whom manual transfer poses potential for staff or patient injury... Note: Although one person can operate most models of mechanical lifts, it's advisable to have two staff members present to stabilize and support the patient...."</p> <p>3.1-45(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and</p>			

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	<p>documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure a GDR (Gradual Dose Reduction) was done as recommended by the Pharmacist for a resident receiving an anti-depressant medication for sleep difficulty. In addition the facility failed to assure behaviors were identified and quantitatively monitored to support the use of an anti-anxiety medication, a stimulant medication and two anti-depressant medications This deficient practice affected 2 of 5 residents reviewed for unnecessary medications. (Residents # 88 and #117).</p> <p>Findings include:</p> <p>1. Resident #88's record was reviewed on 11/17/2014 at 3:30 p.m. The resident's diagnoses included, but were not limited to, malaise and fatigue, history of a fall, difficulty walking, and dysphasia (deficiency in the generation of speech) .</p> <p>The November 2014 physician medication order recapitulation, indicated the resident was receiving, but was not limited to the following medications:</p>	F000329	<p>It is the practice of this facility to comply with F 329 Drug Regimen is Free from Unnecessary Drug <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? -</u> Resident 88 and 117 has been monitored for identification of existing behaviors and tracked per regulatory requirements, reviewed by pharmacist for possible GDR and findings submitted to MD for review. Based on the data and recommendations, new orders carried out as applicable. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -</u> Residents who reside in this facility receiving antidepressants, anxiolytics, or stimulant medications have the potential to be affected by the alleged finding and have been identified through chart reviews. Residents receiving these medications have been reviewed for existing behaviors and have been reviewed by pharmacy consultant to determine if GDR's are recommended. Based on the information forwarded to MD,</p>	12/18/2014

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	<p>alprazolam (anti-anxiety medication) 0.25 mg (milligrams) by mouth two times per day; duloxetine (anti-depressant medication) 30 mg by mouth two times a day; Trazodone (anti-depressant medication) 50 mg at bedtime for insomnia.</p> <p>The resident's record included a note from the consultant pharmacist dated 10/30/2014, to the physician with the following information:</p> <p>"Note Text: To: Attending Physician</p> <p>Patient: [Resident #88's name]</p> <p>Irregularities: Yes, irregularities were noted and recommendations follow.</p> <p>Physician orders: ... TraZODone [sic] HCL Tablet 50 MG Give 50 mg by mouth at bedtime for sleep started upon admission [8/5/2014]</p> <p>Recommendation (s): Trial dose reduction: Please consider reducing the Trazodone to 25 mg po [by mouth] hs [at sleep/bedtime] for insomnia. If any of the above medications are continued at the current dose please document a clinical contraindication to a</p>		<p>GDR's completed as ordered. Residents remaining on identified medications will be re-assessed by Social Services to include justification of continued therapy as appropriate. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Social Service and nursing staff will be educated on appropriate indication for use of Psychotropic Medication and associated documentation requirements. New admissions or existing residents whose medication regimen has been altered with new or increased therapy will be assessed for behaviors, which will include justification for prescribed medications. Residents will be placed on behavior tracking during the assessment process based on regulatory requirements. Social Service and nursing staff who fail to comply with these facility guidelines will be educated and/or progressively disciplined as indicated. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u> Social Service Director or designee will conduct audits of new admissions or those existing patients in which medication has been added or increased daily, 5 times a week x</p>				

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	<p>gradual dose reduction.</p> <p>Physician Response: ... [x] Decline the recommendation (s) above and do not wish to implement any changes due to the reason(s) below: RATIONALE: [hand written] Resident stable / requires dose for insomnia"</p> <p>The resident's record lacked information indicating the resident was continuing to have trouble sleeping.</p> <p>During an interview on 11/18/2014 at 2:00 p.m., RN#10 indicated she was not sure where the Nurse Practitioner got the sleep problem information from.</p> <p>2. Resident #117's record was reviewed on 11/17/2014 at 3:40 p.m., diagnosis included, but were not limited to,SAH (Subarchnoid Hemorrhage -- an uncommon type of stroke caused by bleeding on the surface of the brain), acute respiratory failure, tracheostomy, and depressive disorder.</p> <p>The resident's current physician medication orders included, but were not limited to the following medications: Lorazepam (an anti-anxiety medication) 0.5 mg. Give 1/2 tablet by mouth 3 times a day.</p>		<p>4 weeks and then randomly thereafter x 3 months to validate that systems are sustained and compliance is on-going. Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS/Social Service Director. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.Please see attachments for IDR information.</p>				

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F000371 SS=E	<p>Trazodone(an anti-depressant medication) 50 mg. Give 2 tablets by mouth at bedtime for depressive disorder. Sertraline (an anti-depressant medication) 50 mg. Give 1 tablet by mouth one time a day for depression. Methylphenidate (a stimulant medication) 10 mg. Give 1 tablet twice daily.</p> <p>The resident's record from August 2014 to November 2014 lacked documentation with evidence of behavior monitoring or non-pharmacological interventions for anxiety or attention problems.</p> <p>During an interview on 11/20/2014 at 2:35 p.m., the Assistant Director of Care and Delivery Services indicated the progress notes contain information on the resident's behaviors if there are any.</p> <p>3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food</p>						

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	<p>under sanitary conditions</p> <p>Based on observation and interview, the facility failed to have a dry storage item covered and matter was observed in it. This deficient practice had the potential to affect all 61 residents currently residing in the facility and being served from the kitchen.</p> <p>Findings include:</p> <p>During a kitchen sanitation observation with the Food Service Director on 11/12/2014 at 9:50 a.m., a large container of identified, "corn meal" was observed with the lid off. A small light brown particle was observed in the corn meal.</p> <p>During an interview with the Food Service Director at this time, he indicated there should be a temporary covering over the corn meal. He indicated the lid was off of it, because it was being washed. The small light brown particle, he identified as cardboard. He indicated he would be reviewing policy and procedure with his staff regarding the care and covering of unused dry items.</p> <p>3.1-21(i)(3)</p>	F000371	<p>F-371 It is the practice of this facility to comply with F-371 – Food Procure, Store /Prepare/Serve-sanitary</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u> _ No residents were affected as a result of this alleged finding. The identified dry storage item was discarded and replaced at time of identification. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</u> _ Residents who reside in this facility have the potential to be affected by this alleged finding. Inspection was completed to validate that dry storage items were covered, labeled, and dated per protocol. Any items that were not stored appropriately were disposed and replaced. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u> _ Dietary Staff were educated on the food storage policy. Dietary staff who fails to comply with these company guidelines will be educated and/or progressively disciplined as indicated. <u>How the corrective action(s) will be monitored to ensure the</u></p>	12/18/2014	

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F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview and record review, the facility failed to ensure	F000412	<u>deficient practice will not recur, i.e., what quality assurance program will be put into place:</u> _ Dietary Manager/designee will monitor, utilizing an audit tool, for the storage of dry food items 5 days a week x 4 weeks. Afterwards random monitoring will occur weekly x 3 months . Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS/Food Service Director. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing. F412 It is the practice of this facility to comply with F412	12/18/2014	

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	<p>dental services were provided in a timely manner for 1 of 3 residents reviewed for dental services. (Resident # 105)</p> <p>Findings include:</p> <p>Resident # 105's record was reviewed on 11/18/14 at 5:35 p.m. Diagnoses included, but were not limited to, intracerebral hemorrhage, depressive disorder, cognitive deficits, aphasia, anxiety state and cerebrovascular disease.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 10/29/14, indicated the resident's BIMS (Brief Interview for Mental Status) was 12, which was moderately cognitively impaired. The dental section indicated the resident did not have any obvious or broken natural teeth.</p> <p>On 11/13/14 at 11:56 a.m., the resident was observed with missing and broken teeth on the upper and lower gums and his teeth were discolored a brown color.</p> <p>On 11/18/14 at 12:40 p.m., the resident was observed receiving a bun with Coney sauce and melted cheese with peas and a brownie for lunch.</p> <p>A dental progress note dated 4/29/14, indicated "Exam Summary: Dental</p>		<p>Routine/Emergency Dental Services <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident 105 was seen by the dentist on _____, and an action plan has been initiated. <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Residents who have missing or broken teeth and/or has oral pain have the potential to be affected by this alleged finding. An interview was conducted to alert and oriented residents on condition of teeth or oral pain and preference for referral for dental evaluation. Non-interviewable residents were assessed for missing/broken teeth or oral pain. An audit was completed to record findings. No emergency dental concerns were identified. Residents identified as having a dental concern will be scheduled to see the dentist within a timeframe commensurate with the concern.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Registered Nurse at time of admission, quarterly, and with significant change will assess oral status and complete section L, based on RAI instructions. Any</p>	

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	<p>Exam...Tooth Notes: pt [patient] has multiple decayed and broken teeth pt complains of pain around the area of #4 it needs to be extracted. Referral written for remaining teeth to be extracted due to severe periodontal disease. Oral Examination:... Oral Hygiene: Fair Gingival Tissue: Healthy Subgingival Calculus Level: Mimimal [sic] Supragingival Calculus Level: Mimimal [sic] Debris Level: Mimimal [sic] Bleeding: None Is the patient a candidate for perio scaling: No Is the patient edentulous: No... Treatment Plan:...Schedule: Next Visit-Referral Follow up...."</p> <p>A dental referral form dated 4/29/14, indicated "...Refer To: General DDS [Doctor of Dental Surgery] Referred For: full mouth extraction... Notes: Recommend for pt [patient] to have a full mouth extraction due to periodontal dis [disease] PLEASE FORWARD ALL REPORTS TO: [name of dental service]...."</p> <p>A progress note dated 4/29/14 at 4:23 p.m., indicated "resident seen dentist today regarding mouth pain. Res c/o [complaints/ of] of pain when chewing his food. Writer offered res [resident] to be placed on a softened diet [a diet with soft foods that can be chewed easily] &</p>		<p>identified concerns will be communicated to charge nurse and Social Services to facilitate appointment or dental evaluation. For times outside of the regularly scheduled assessments, any new complaints of oral pain or newly identified broken/missing teeth will be assessed and referred to the dentist for follow-up per resident's preference. Nurse managers will review progress notes daily and report any dental concerns during morning meeting to facilitate a plan of care for the affected resident. Licensed nurses and Certified aides will be educated on signs and symptoms of what could be a potential dental concern or emergency, and protocol to follow to ensure the resident's dental need is met.</p> <p>Licensed nurses will be educated on resident assessment, documentation and follow through of findings related to dental concerns. Staff who fail to comply with expectation of assessment, documentation and follow through will be re-educated and/or progressively disciplined as indicated. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</u></p> <p>Administrative Director of Nursing or designee will conduct audits for residents identified with dental concerns and validate assessment completed,</p>				

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	<p>he refused stated 'I don't want my meat chopped up, I just pick & chose what I want to eat'."</p> <p>A dental progress note dated 10/24/14, indicated "Exam Summary: Dental Exam...Tooth Notes: Referral written @ [at] Pt [Patient] request for full mouth extraction...This order done at last appt [appointment] by [name of doctor]; today, 10/24/14 came to take impressions for C/C [Chief/Complaint] but pt had never been out. New referral written w/ [with] RN [registered nurse] made aware of it. Oral Examination... Oral Hygiene: Poor Gingival Tissue: Inflamed... Notes: New referral written for extraction of all remaining teeth...."</p> <p>A progress noted dated 10/28/14 at 2:52 p.m., indicated "Resident seen by Dentist 10/24/14. He was referred to see an oral surgeon to remove all remaining teeth for future denture fabrication. [Name, address and phone number of Dentist] was contacted today for a consultation apt [appointment] 11/6 @ [at]11:30. Resident was contacted regarding this."</p> <p>A progress note dated 11/5/14 at 10:18 a.m., indicated "Resident oral surgery consultation appt [appointment] was canceled due to medicaid pending. Office stated they are not able to see the</p>		<p>documented, and that referral has been completed and carried out as ordered. The audit will be completed daily, 5 days a week x 4 weeks and then random audits will continue weekly x 3 months to validate systems are sustained. Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p>				

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	<p>patient because of this and they do not except Medicare. Transportation was notified and canceled as well. Social Services provided a list to contact other providers for possible appt. Staff is aware of this change and resident notified of this change as well."</p> <p>A progress note dated 11/12/14 at 2:23 p.m., indicated "Contacted [name of dental service] regarding resident getting impressions pre or post tooth extractions. Left another msg [message] for [name of person] w/ [with] [name of dental service]; awaiting response. Oncoming nurse notified of this as well."</p> <p>A progress note dated 11/18/14 at 9:56 a.m., indicated "[Name of Dentist] met with pt. [patient] on 11/18/14 to inform pt. that they could not do impression until the teeth were extracted. Once the teeth are extracted. [name of dental service] will be able to make the molds for the dentures. [Name of Dentist] also states that teeth extractions are not covered under Medicare. Dentist stated that he spoke with pt. and informed him of this information."</p> <p>A progress note dated 11/18/14 at 10:01 a.m., indicated "Pt is aware that since his medicaid is not active at this time his teeth extractions has been delayed.</p>			

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	<p>Nursing is attempting to locate other oral surgeons to perform teeth extraction at this time and will keep pt [patient] updated on progress."</p> <p>A progress note dated 11/19/14 at 10:51 a.m., indicated "Writer made call to [Name of Oral Surgeon] office regarding extraction of remaining teeth in order to cont [continue] with process of denture fitting. [Name of Oral Surgeon] administrative assistant stated Medicare will not cover teeth extraction. Assistant stated that res [resident] needs to have Medicaid active in order to have procedure done. SSD (Social Service Director), DCD Director of Care Delivery, and ADNS (Assistant Director of Nursing Services) notified of phone call to office of [Name of Oral Surgeon] and [Name of Dentist] and denial of medicare."</p> <p>During an interview on 11/13/14 at 11:47 a.m., Resident # 105 indicated he bit his lips, inside of his mouth and occasionally his tongue causing sores because the way his teeth was positioned due to the lack of teeth on the top and bottom. He indicated he skipped meals sometimes depending on the food that was being served for that meal because he can only eat foods that were soft. He indicated he had saw a dentist here at the facility and</p>			

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	<p>he asked him some questions, but he had not been told that anyone had set up an appointment to have his teeth extracted.</p> <p>During an interview on 11/19/14 at 10:01 a.m., Resident # 105 indicated the dentist and his assistant asked him his name yesterday, but had not examined his teeth. He indicated he could not drink anything hot because his teeth were sensitive and the hot beverages made his teeth hurt. He indicated he felt like he was running up against a stone wall and he got angry. He indicated he felt like he wanted to act out, but he knew he should not have behaviors. He indicated he wanted his teeth extracted and get dentures, so he could eat and enjoy his food without biting the inside of his mouth, lips and tongue. He indicated he felt like he had gotten swept under the rug when he asked about when his teeth were going to get extracted or about the dentist.</p> <p>During an interview on 11/19/14 at 10:40 a.m., the SSD indicated she was responsible for scheduling the dental appointments for the residents.</p> <p>During an interview on 11/19/14 at 11:22 a.m., the BOM (Business Office Manager) indicated Resident # 105 had Medicaid when he was admitted to the</p>			

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R000000	<p>facility at the end of January 2014, but he lost his Medicaid on June 1, 2014.</p> <p>During an interview on 11/19/14 at 5:03 p.m., the SSD indicated she was responsible for the [Name of Dental service] dental appointments and the Nursing staff were responsible for the other consult dental appointments. She indicated the Dentist from [Name of Dental service], when he was finished examining the residents gave his notes and referral forms to the floor nurses and the floor nurses were responsible for setting up the referral appointments. She indicated Resident # 105's referral appointment written on 4/29/14, must have gotten overlooked and that was the reason he did not have his teeth extracted yet.</p> <p>3.1-24(a)</p> <p>The following residential findings were cited in accordance with 410 AIC 16.2-5.</p>	R000000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the		

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R000026	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on interview and record review, the facility failed to ensure the Indiana Resident Rights document was signed and dated by 1 of 7 residents reviewed for documentation of signed and dated residents rights. (Resident #19)</p> <p>Findings include: Resident # 19's record was reviewed on</p>	R000026	<p>facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p> <p>R026 Resident Rights It is the practice of this facility to comply with R026, Residents Rights What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #19 has signed the Indiana Resident Rights document. How other residents having the potential to be affected by the same</p>	12/18/2014

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	<p>11/21/14 at 12:47 p.m. Diagnoses included, but were not limited to, left foot drop, venous insufficiency, peripheral vascular disease, lower extremity edema, peripheral neuropathy, valvular heart disease, mitral regurgitation, blind left eye, and arthritis left knee.</p> <p>The resident's record lacked a signed and dated copy of the Indiana Resident Rights document.</p> <p>During an interview on 11/21/14 at 1:40 p.m., the Wellness Director (WD) indicated she could not find a signed and dated copy of the Resident Rights document in the resident's record, but she would check the business office to see if it was down there in that file.</p> <p>During an interview on 11/21/14 at 2:22 p.m., the WD indicated she had checked with the business office and the resident did not have a signed and dated Resident Right document in her file. She indicated at that time there was no signed or dated Resident Right document for this resident.</p>		<p>deficient practice will be identified and what corrective actions(s) will be taken? Residents who reside in this facility have the potential to be affected by this alleged finding. What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur? We will audit admission records and ensure that Resident Rights documents have been signed. We will educate appropriate staff to recognize the need for Resident Rights to be signed upon admission. Staff who fails to comply with expectations of having Resident Rights documents signed upon admission will be educated and or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Wellness Director will check records of new admissions weekly for three months to ensure new residents have signed the Resident Rights documents. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2014
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NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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R000036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on interview and record review, the facility failed to notify the physician and the resident's legal representative regarding a change of condition of a resident's left lower extremity for 1 of 5 residents reviewed for changes in condition in a sample of 7. (Resident # 19)</p> <p>Findings include:</p> <p>Resident # 19's record was reviewed on 11/21/14 at 12:47 p.m. Diagnoses included, but were not limited to, left foot drop, venous insufficiency, peripheral vascular disease, lower extremity edema, peripheral neuropathy, valvular heart disease, mitral regurgitation, blind left eye, and arthritis left knee.</p>	R000036	<p>Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>It is the practice of this facility to comply with R036, Residents Rights What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #19 has had family and physician notified in change of condition. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? Residents who reside in this facility have the potential to be affected by this alleged finding. What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur? We will review clinical records and</p>	12/18/2014

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	<p>A Treatment Administration Record (TAR) dated October 2014, indicated the residents Ted Hose had been held on 10/20/14. The back of the TAR indicated "10/20/14 11 am Residents left calf had a large bruise (red) with a purple blood filled bulla [blister]. I advised her not to put ted hose on left lower leg."</p> <p>No documentation was found in the resident's record to indicate the Physician or the resident's legal representative had been notified of the blister that was discovered on her left lower leg on 10/20/14.</p> <p>An Interdisciplinary Progress Note dated 10/26/14 at 9 p.m., indicated "Resident has 3 x 2 area to left posterior leg blister on area open serosanguinous [sic] drainage from area. MD [Medical Doctor] notified. [name of doctor] on call instructed writer to order venous Doppler to check for DVT [deep venous thrombosis], order Keflex [An antibiotic medication] 500 mg [milligrams] BID [twice daily] if DVT negative...family aware."</p> <p>During an interview on 11/21/14 at 1:55 p.m., the Wellness Director indicated she could not find documentation in the resident's record to show the resident's</p>		<p>ensure that no changes in condition occurred without documentation of family and physician notification. We will educate Nursing Staff to recognize the need for family and physician notification upon notice in change of condition. Nursing Staff who fail to comply with expectations of notifying resident family and physician will be educated and or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Wellness Director will review the 24 hour report for change of condition 5X weekly for three weeks; then weekly for an additional 4 weeks to ensure residents that have a change in condition have had their family and physician notified timely. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p>		

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R000214	<p>Physician or legal representative had been notified regarding the change of condition of the resident's left lower extremity on 10/20/14.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to have an updated evaluation reflecting the change in the resident's left lower extremity status for 1 of 5 residents reviewed for evaluations in a sample of 7. (Resident # 19)</p> <p>Findings include:</p> <p>Resident # 19's record was reviewed on 11/21/14 at 12:47 p.m. Diagnoses included, but were not limited to, left foot drop, venous insufficiency, peripheral vascular disease, lower extremity edema, peripheral neuropathy, valvular heart disease, mitral regurgitation, blind left eye, and arthritis left knee.</p> <p>A Treatment Administration Record</p>	R000214	<p>It is the practice of this facility to comply with R214, Evaluation of Individual Needs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #19 has had the clinical record reviewed and it has been updated to reflect current condition and service plans. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? Residents who reside in this facility have the potential to be affected by this alleged finding. What measures will be put into place of what systemic changes will be made to ensure that the deficient</p>	12/18/2014

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	<p>(TAR) dated October 2014, indicated the residents Ted Hose had been held on 10/20/14. The back of the TAR indicated "10/20/14 11 am Residents left calf had a large bruise (red) with a purple blood filled bulla [blister]. I advised her not to put ted hose on left lower leg."</p> <p>An Interdisciplinary Progress Note dated 10/26/14 at 9 p.m., indicated "Resident has 3 x 2 area to left posterior leg blister on area open serosanguinous [sic] drainage from area. MD [Medical Doctor] notified. [name of doctor] on call instructed writer to order venous doppler to check for DVT [deep venous thrombosis], order Keflex [An antibiotic medication] 500 mg [milligrams] BID [twice daily] if DVT negative...family aware."</p> <p>There was no documentation of an assessment of the resident's LLE (left lower extremity) wound found in the resident's record from 10/20/14 to 10/26/14.</p> <p>An Interdisciplinary Progress Note dated 11/4/14 at 5 p.m., indicated "Resident went to [name of doctor]; rec'd [received] new orders for Kclor [sic] [an electrolyte supplement], Lasix [a diuretic medication] et [and] Keflex; also referral for wound care nurse to evaluate and treat</p>		<p>practice does not recur? We will review clinical records and ensure that changes in condition that have occurred will be noted and the service plan updated. We will educate Nursing Staff to recognize the need for updated service plans when change of condition occurs. Nursing Staff who fail to comply with updating service plans when change of condition occurs will be educated and or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Wellness Director will check the 24 hour report for change of condition 5X weekly for three weeks then weekly for an additional 4 weeks to ensure all residents that have a change in condition have had their service plans updated. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p>				

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	<p>lower left leg wound. Res agreed to referral to [name of Home Health company] to do wound care eval [evaluation] and treatment...Res had quarter size open area on Left lower leg; telfa pad applied to cover area."</p> <p>There was no documentation of an assessment of the resident's LLE wound found in the resident's record from 10/26/14 to 11/04/14.</p> <p>There was no documentation of an assessment of the resident's dressing on the LLE wound by the facility nurses found in the resident's record from 11/4/14 to 11/21/14.</p> <p>A Home Health Wound Page dated 11/13/14 at 11:45 a.m., indicated the resident's wound was to her LLE Posterior Tibia. She had a vascular wound. The wound measured 3.2 x 3.2 x 0.3 cm (centimeters). The wound had a moderate amount of serous drainage. The surrounding tissue was pink. The dressing was changed.</p> <p>There was no documentation found on the resident's current evaluation dated 5/23/14, that indicated the resident had a LLE wound.</p> <p>The resident's "Service Agreement</p>						

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R000216	<p>Addendum" dated 5/23/14, was deemed current by the Wellness Director and indicated there was no documentation on the evaluation that indicated the resident had a LLE wound.</p> <p>During an interview on 11/21/14 at 1:40 p.m., the Wellness Director (WD) indicated the Service Agreement Addendum was also the resident's Semi-annual Evaluation. She indicated the resident's Evaluation had not shown the changes related to her LLE wound.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to have a completed self administration assessment for a resident who self administered insulin for 1 of 2 residents reviewed for self medication administration. (Resident # 28).</p>	R000216	<p>It is the practice of this facility to comply with R216, Evaluation; Self Administration Assessment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>	12/18/2014			

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	<p>Findings include:</p> <p>Resident # 28's record was reviewed on 11/21/14 at 1:56 p.m. Diagnoses included, but were not limited to, anoxic brain injury, diabetes mellitus, depression and acute renal failure.</p> <p>The recapitulation (recap) dated November 2014, included, but were not limited to the following orders: 12/9/13-Accuchecks BID (Twice daily). 6/26/14-Novolog Flexpen Syringe inject 8 units subcutaneously every morning. Okay to hold dose if not eating. Scheduled at 5 p.m. 12/10/13-Levemir Flexpen 100 units/ml (milliliter) inject 8 units subcutaneously at bedtime. Scheduled at 8 p.m.</p> <p>The March 2014-November 2014, Medication Administration Records indicated the resident self-administered all his insulin doses.</p> <p>The resident's Service Agreement Addendum dated 6/25/14, indicated "...5. Medication Administration 8-Medication reminders/delivery required up to two times per day (does not include insulin or med upon request). Medication Observation: Diabetic management: Resident administers Insulin BID [twice</p>		<p>practice? Resident #28 has had the self-administration assessment completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? Residents who reside in this facility have the potential to be affected by this alleged finding. What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur? We will review clinical records and ensure any resident who self-medicates has a self-administration assessment. We will educate Nursing Staff to recognize the need for self-administration assessments on residents who have the ability to self-administer their own medications. Nursing Staff who fail to comply with providing self-administration assessments on those who self-administer medications will be educated and or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Wellness Director will monitor new admissions for the possibility of self-medication and ensure the self-administration assessment has been completed,</p>				

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R000217	<p>daily]. Medication Observations and Service Plan: Nursing administers oral meds 12 N and HS [bedtime]... 13. Care management (i.e. hearing aides, battery change, TED Hose, weights, accuchecks, oxygen saturation levels, B/P) 0-No services required. Care Management Observations and Service Plan: Accuchecks per resident BID...."</p> <p>There was no self medicate order or self administration evaluation documentation found in the resident's record to enable him to self administer his own insulin.</p> <p>During an interview on 11/21/14 at 2:12 p.m., LPN # 2 indicated the resident slept until noon or after every day because he was a "nightowl". She indicated the resident did not have a self administration evaluation document to self administer his insulin.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference;</p>		1X weekly for eight weeks to ensure residents that self-administer medications have a self-administration assessment completed. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.				

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	<p>of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to have an updated service plan reflecting the service provided for 1 of 5 residents reviewed for service plans in a sample of 7. (Resident # 19)</p> <p>Findings include:</p> <p>Resident # 19's record was reviewed on 11/21/14 at 12:47 p.m. Diagnoses included, but were not limited to, left foot drop, venous insufficiency, peripheral vascular disease, lower extremity edema, peripheral neuropathy, valvular heart disease, mitral regurgitation, blind left eye, and arthritis left knee.</p> <p>A Treatment Administration Record</p>	R000217	<p>It is the practice of this facility to comply with R217, Evaluation; Service Agreement Addendum</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #19 has had the Service Agreement Addendum updated to reflect current treatment being provided.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? Residents who reside in this facility have the potential to be affected by this alleged finding. What measures will be put into place of what systemic changes will be made to ensure that the deficient</p>	12/18/2014

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	<p>(TAR) dated October 2014, indicated the residents Ted Hose had been held on 10/20/14. The back of the TAR indicated "10/20/14 11 am Residents left calf had a large bruise (red) with a purple blood filled bulla [blister]. I advised her not to put Ted hose on left lower leg."</p> <p>An Interdisciplinary Progress Note dated 10/26/14 at 9 p.m., indicated "Resident has 3 x 2 area to left posterior leg blister on area open serosanguinous [sic] drainage from area. MD [Medical Doctor] notified. [name of doctor] on call instructed writer to order venous Doppler to check for DVT [deep venous thrombosis], order Keflex [an antibiotic medication] 500 mg [milligrams] BID [twice daily] if DVT negative...family aware."</p> <p>An Interdisciplinary Progress Note dated 11/4/14 at 5 p.m., indicated "Resident went to [name of doctor]; rec'd [received] new orders for Kclor [sic] [an electrolyte supplement], Lasix [a diuretic medication] et [and] Keflex; also referral for wound care nurse to evaluate and treat lower left leg wound. Res agreed to referral to [name of Home Health company] to do wound care eval [evaluate] and treatment...Res had quarter size open area on Left lower leg; telfa pad applied to cover area."</p>		<p>practice does not recur? We will review clinical records and ensure residents who have an outdated Service Agreement Addendum have one updated to reflect current treatment being provided. We will educate Nursing Staff to recognize the need for updated Service Agreement Addendums on residents who are provided additional services after their initial Service Agreement. Nursing Staff, who fail to comply with updating Service Agreement Addendums, will be educated and or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Wellness Director will monitor the 24 hour report for the possibility of needed Service Agreement Addendums, 5X weekly for three weeks and then weekly for 8 weeks to ensure residents that self-administer medications have a self-administration assessment completed. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing</p>				

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R000273	<p>A Home Health Wound Page dated 11/13/14 at 11:45 a.m., indicated the resident's wound was to her LLE Posterior Tibia. She had a vascular wound. The wound measured 3.2 x 3.2 x 0.3 cm (centimeters). The wound had a moderate amount of serous drainage. The surrounding tissue was pink. The dressing was changed.</p> <p>The resident's "Service Agreement Addendum" dated 5/23/14, was deemed current by the Wellness Director and indicated there was no documentation on the Service Plan that indicated the resident had a LLE wound or she had wound care being completed by Home Health Care.</p> <p>During an interview on 11/21/14 at 1:40 p.m., the Wellness Director (WD) indicated the Service Agreement Addendum (Service Plan) had not shown the resident had been placed on Home Health Care (HHC) for dressing changes for a wound to the LLE.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p>		compliance and accept and/or make recommendations monthly ongoing.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
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	<p>Based on observation and interview, the facility failed to have a dry storage item covered and matter was observed in it. This deficient practice had the potential to affect all 87 residents currently residing in the assisted living area of the facility and being served from the kitchen.</p> <p>Findings include:</p> <p>During a kitchen sanitation observation with the Food Service Director on 11/12/2014 at 9:50 a.m., a large container of identified, "corn meal" was observed with the lid off. A small light brown particle was observed in the corn meal.</p> <p>During an interview with the Food Service Director at this time, he indicated there should be a temporary covering over the corn meal. He indicated the lid was off of it, because it was being washed. The small light brown particle, he identified as cardboard. He indicated he would be reviewing policy and procedure with his staff regarding the care covering of unused dry items.</p>	R000273	<p>It is the practice of this facility to comply with F-371 – Food Procure, Store /Prepare/Serve-sanitary <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u> _ No residents were affected as a result of this alleged finding. The identified dry storage item was discarded and replaced at time of identification. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</u> _ Residents who reside in this facility have the potential to be affected by this alleged finding. Inspection was completed to validate that dry storage items were covered, labeled, and dated per protocol. Any items that were not stored appropriately were disposed and replaced. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</u> _ Dietary Staff were educated on the food storage policy. Dietary staff who fails to comply with these company guidelines will be educated and/or progressively disciplined as indicated. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</u></p>	12/18/2014	

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R000409	<p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on interview and record review, the facility failed to include an annual health statement for 1 of 7 residents reviewed. (Resident #12)</p> <p>Findings included :</p>	R000409	<p><u>i.e., what quality assurance program will be put into place:</u> _ Dietary Manager/designee will monitor, utilizing an audit tool, for the storage of dry food items 5 days a week x 4 weeks. Afterwards random monitoring will occur weekly x 3 months . Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS/Food Service Director. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>It is the practice of this facility to comply with R409, Infection Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident</p>	12/18/2014

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	<p>On 11/21/14 at 1:00 p.m., the record review for Resident #12 was completed. Diagnoses included, but were not limited to, diabetes, Stage III healing wound and COPD (Chronic Obstructive Pulmonary Disorder).</p> <p>The Physician Recapitulations were reviewed from admission on 7/22/14 through November 2014. There was a statement indicating there was no communicable disease, however each of the documents lacked verification from the physician.</p> <p>On 11/21/14 at 2:30 p.m., the Executive Director indicated he could not locate any documentation of verification of the resident being free of communicable disease.</p>		<p>#12 record has been updated to include the physician's signature on the communicable disease statements. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? Residents who are admitted to this facility have the potential to be affected by this alleged finding. What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur? We will review clinical records and ensure residents who do not have a communicable disease statement signed by the physician, will have the statement verified and signed. We will educate Nursing Staff to recognize the need for communicable disease statements signed by the physician. Nursing Staff who fail to comply with obtaining a free from communicable disease statement will be educated and or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? Wellness Director will monitor new admissions and ensure there is a statement signed by the physician verifying</p>		

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			the patient is free from communicable diseases, 1X weekly for eight weeks to ensure residents that are admitted have a free from communicable disease statement signed by the physician. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.		