

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/06/2014
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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the State Residential Licensure Survey.</p> <p>Survey dates: October 27, 28, 29, 30, & 31, 2014. November 3, 5, & 6, 2014.</p> <p>Facility number: 012305 Provider number: 155779 AIM number: 200987990</p> <p>Survey team: Gloria Bond, RN--Team Coordinator Michelle Hosteter, RN Sandra Nolder, RN</p> <p>Census bed type: SNF: 40 SNF/ NF: 10 Residential: 48 Total: 98</p> <p>Census payor type: Medicare: 11 Medicaid: 10 Other: 29 Total: 50</p> <p>Residential Sample: 10</p>	F000000		

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>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on November 13, 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>			

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	<p>Based on observation, interview and record review, the facility failed to ensure staff provided privacy of body during ADL (Activities of Daily Living) care for 2 of 2 residents reviewed for privacy. (Resident #6 and #73)</p> <p>Findings include:</p> <p>1. On 10/30/14 at 9:43 a.m., Resident # 6's record was reviewed. Diagnoses included, but were not limited to, depressive disorder, dementia, expressive aphasia (unable to communicate verbally), and stroke with right hemiplegia (one sided paralysis).</p> <p>The resident's admission MDS (Minimum Data Set) assessment dated 10/3/14, indicated the following: She had a BIMS (Brief Interview for Mental Status) score of 0, which indicated she was severely cognitively impaired.</p> <p>Her functional status indicated she was an extensive assist with a one person physical assist with personal hygiene. Her functional status indicated she was an extensive assist with a two person physical assist with dressing.</p> <p>On 10/30/14 at 1:30 p.m., CNA # 4 and CNA # 5 were observed assisting Resident # 6 into bed, then removing her</p>	F000164	<p>F164</p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings</i></p> <p><i>R/T to F164, the following</i></p> <p><i>Actions will be taken:</i></p> <p>A) With respect to these findings, 2 of the 2 residents reviewed for privacy in the skilled nursing unit in the Health Care Center had the potential to be affected.</p>	12/05/2014

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	<p>pants and brief. CNA # 4 and CNA # 5 were observed providing peri-care for her while her privacy curtain was observed open. CNA # 6 was observed at the foot of the resident's bed holding the plastic trash bag for the other two CNA's during the personal care. The resident's roommate was observed laying down in her bed facing away from the resident until another staff member came in to assist her with dressing and she sat up on the edge of the bed.</p> <p>During an interview on 10/30/14 at 1:54 p.m., CNA # 4 indicated that while she was providing personal care for the resident, she should have closed the privacy curtain.</p> <p>During an interview on 10/31/14 at 4:15 p.m., the ADHS (Assistant Director of Health Services) indicated the CNA's should have closed the privacy curtain while providing personal care for the resident.</p> <p>2. On 11/3/14 at 2:40 p.m., Resident # 73's record was reviewed. Diagnoses included, but were not limited to, Alzheimer's, depression, anxiety and dementia with behaviors.</p> <p>The resident's quarterly MDS assessment dated 8/8/14, indicated the following:</p>		<p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action: <i>Nursing Leadership will monitor during hourly rounding to identify any potential concerns.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>DHS and/or designee with the assistance of Social Services will in-service all Nursing staff on Resident Rights/ Privacy & Dignity</i></p> <p>D) With respect to how the plan of corrective measures will be monitored:</p>	

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F000167 SS=C	<p>She had a BIMS score of 5, which indicated she was severely cognitively impaired.</p> <p>Her functional status indicated she was an extensive assist with a one person physical assist with dressing.</p> <p>On 10/30/14 at 1:45 p.m., Resident # 73 was observed changing her clothes with LPN # 10 assisting her. The resident indicated while changing her clothes, "Don't you look at me." The resident's pajama top was observed to be unbuttoned and her breasts were visible. The curtain between the resident and her roommate's bed was observed open and there was no privacy curtain observed around her bed while changing her clothes.</p> <p>During an interview on 10/31/14 at 4:15 p.m., the ADHS indicated LPN # 10 should have closed the privacy curtain while changing the resident's clothes.</p> <p>3.1-3(p)(4)</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p>		<p>DHS and/or designee will <i>audit</i></p> <p><i>1 time per weekly for 3 month with the results of the audit observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation.</i></p> <p>E) Date of compliance with proposed actions: 12/05/14</p>				

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	<p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure past survey results were readily accessible to residents, families and visitors. This deficient practice had the potential to impact 50 of the 50 residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview on 10/27/14 at 10:15 a.m., the Executive Director was informed the most recent annual survey was not in the survey book. At that time, he checked the book and indicated the annual survey was not in the book, but it had been in the book. He indicated he would place another copy of the annual survey in the book.</p> <p>3.1-3(b)(1)</p>	F000167	<p>F167</p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings</i></p> <p><i>R/T to F167, the following</i></p> <p><i>Actions will be taken:</i></p> <p>A) With respect to these findings,</p> <p><i>All 50 of the 50 residents</i></p> <p><i>in the skilled nursing unit in</i></p> <p><i>the Health Care Center had</i></p>	11/25/2014

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			<p><i>the potential to be affected</i></p> <p><i>by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action:</p> <p><i>All 50 of the 50 residents in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern:</p> <p><i>The 2013 annual survey was immediately replaced in the public survey binder.</i></p> <p>D) With respect to how the plan of</p>	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow	F000282	corrective measures will be monitored: <i>The ED or designee will audit binder</i> <i>1 time per month for 3 month with</i> <i>the results of the audit</i> <i>observations reported, reviewed</i> <i>and trended for compliance</i> <i>thru the campus Quality</i> <i>Assurance Committee</i> <i>for a minimum of 3 months</i> <i>then randomly thereafter</i> <i>for further recommendation.</i> E) Date of compliance with proposed actions: November 25, 2014 <u>F282</u>	12/05/2014

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	<p>care plans for 2 residents needing fall prevention interventions and safe transferring methods (Residents #37 & #6), and 2 residents requiring incontinence care (Resident #6 & #98). This deficient practice affected 3 of 21 residents reviewed.</p> <p>Findings include:</p> <p>1. Resident #37's record was reviewed on 10/30/2014 at 10:46 a.m. Diagnoses included, but was not limited to, dementia, legal blindness, and a history of falls.</p> <p>During an observation on 11/3/2014 at 11:45 a.m., Resident #37 was observed unattended and reaching down trying to adjust his Velcro shoe strap.</p> <p>During an observation and interview on 11/3/2014 at 12:10 p.m., with LPN # 7 , the resident's safety chair alarm clip was observed attached to the back of his wheelchair. At this time LPN #7, indicated the alarm clip should be attached to the resident.</p> <p>The resident's current, "...Individual Plan Report" indicated the following: "...Place a PSA [personal safety alarm] on my bed /chair ... to remind me to ask for assist with transfers and to alert you if I don't...</p>		<p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings R/T to F282, the following Actions will be taken:</i></p> <p>A) With respect to these findings, Resident #37-Personal Safety Alarm attached to person.</p> <p>Resident #6 checked upon rising, before/after meals, before bed and PRN, lift required for transfers per care plan. Resident# 98 assure</p>	

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	<p>Resident not to be left alson [sic] in room...."</p> <p>2a. On 10/30/14 at 9:43 a.m., Resident # 6's record was reviewed. Diagnoses included, but were not limited to, stroke with right hemiplegia (one sided paralysis), expressive aphasia (inability to communicate verbally), dementia, contracture of the right hand and right knee and osteoarthritis.</p> <p>A document titled "CORP [Care of Resident Profile]-Individual Plan Report" dated 10/31/14, indicated "ACUTE CARE NEEDS: ...9/23/14-I have had a stroke. I have severe right sided hemiplegia. I am non-weight bearing and require the assist of 2 people to transfer with the Maxi-Lift... 9/23/14-Falls: I am at risk for falls r/t [related/to] right sided weakness and decreased mobility. Place my bed at an appropriate level for my body height to facilitate safe transfers...."</p> <p>A document titled "Nursing Admission Assessment & Data Collection" dated 9/22/14, indicated the resident's Mobility and ADL (Activity and Daily Living) indicated the resident was non-weightbearing, dependent with transfers and required extensive assist with 2 person physical assist and she had contractures to her right upper hand and right lower leg. The Mobility and ADL</p>		<p><i>toileting as requested/as needed</i></p> <p><i>per care plan. All 50 of the 50 residents</i></p> <p><i>in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action: <i>Nursing Leadership will monitor during hourly rounding to observe for any concerns</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>DHS and/or designee will in-service all nursing staff on Caretracker</i></p>	

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	<p>Plan of Care section indicated the resident was a transfer with an assist of two persons and a mechanical lift.</p> <p>During an observation on 10/30/14 at 1:30 p.m., CNA # 4 and CNA # 5 transferred the resident to bed by placing a gait belt around the resident's waist while she was in the broda chair. Each CNA had one arm under each one of her arms and lifted her out of her broda chair and placed her into her bed by holding onto the gait belt while lifting the resident.</p> <p>During an interview on 10/31/14 at 4:15 p.m., the ADHS (Assistant Director of Health Services) indicated the CORP-Individual Plan Report was located on the "Caretracker" computer system and the CNA's used the information from that report to provide care for the residents instead of a CNA assignment sheet. She indicated Resident # 6's CORP-Individual Plan Report indicated she was to be transferred with a mechanical lift.</p> <p>During an interview on 11/3/14 at 12:58 p.m., the ADHS indicated Resident # 6 was to be transferred by a mechanical lift to safely transfer the resident.</p> <p>2b. Resident # 6 had a Care Plan dated</p>		<p><i>Care Plan review and utilization per campus policy and procedures.</i></p> <p>D) With respect to how the plan of corrective measures will be monitored: DHS and/or designee will <i>do random 1 time per weekly for 3 month with the results of the audit observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation.</i></p> <p>E) Date of compliance with proposed actions: 12/05/14</p>	

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	<p>9/22/14, that addressed the problem the resident had the following risk factors that contributed to incontinence, which was her cognition or inability to recognize the need to eliminate, medical factors and lack of sensation.</p> <p>The Elimination Plan of Care included, but was not limited to, "9/22/14--...Check and change incontinence product q [every] shift q 2 hours + [and] prn [as needed]...."</p> <p>These observations were made on the following dates and times:</p> <p>During a continuous observation of the resident on 10/30/14 from 9:26 a.m., to 1:30 p.m., there were no observations of Resident # 6 being checked for incontinence or her brief being changed every two hours.</p> <p>On 10/30/14, at the following times the resident was observed in the Pioneer Way lounge sitting in her broda chair watching TV. At 9:26 a.m., 10:40 a.m., and 11:20 a.m.</p> <p>At 11:45 a.m., she was observed to have a urine odor while standing next to her.</p> <p>On 10/30/14 at 11:50 a.m., the resident was taken from the Pioneer Way TV</p>			

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	<p>lounge to the assist dining room.</p> <p>On 10/30/14 at 1:00 p.m., the resident was brought from the assist dining room to the Pioneer Way TV lounge and placed in front of the TV.</p> <p>On 10/30/14 at 1:13 p.m., CNA # 4 was observed asking Resident # 6 if she wanted to lay down and watch TV in her room. The resident indicated at that time she did not want to lay down. CNA # 4 was observed moving the resident's broda chair in front of the TV.</p> <p>On 10/30/14 at 1:30 p.m., CNA # 4 and CNA # 5 were observed transferring Resident # 6 to bed. While the resident was laying in bed, before her pants and brief were removed, a strong urine odor was detected. CNA # 4 and CNA # 5 were observed providing peri-care for the resident and placing a new brief on her. When the brief that was moderately saturated with amber colored urine was removed from the resident, there were indentation lines observed on the resident's buttocks and her inner groin areas. A very strong urine odor was detected at that time.</p> <p>During a continuous observation of the resident on 10/31/14 from 8:45 a.m., to 11:50 a.m., there were no observations of</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident # 6 being checked for incontinence or her brief being changed every two hours.</p> <p>On 10/31/14 at 8:45 a.m., the resident was observed to be taken to her room and placed in bed and incontinence care given.</p> <p>On 10/31/14 at 10:37 a.m., the resident remained in bed and CNA # 4, who was her CNA left the unit for a break.</p> <p>On 10/31/14 at 11:08 a.m., the resident remained in bed.</p> <p>On 10/31/14 at 11:18 a.m., CNA # 4 returned to the unit.</p> <p>On 10/31/14 at 11:25 a.m., CNA # 4 and RN # 2 attempted to assist the resident up for lunch and she refused to get up for lunch, so both staff members left the resident's room.</p> <p>On 10/31/14 at 11:50 a.m., an unidentified CNA was observed pushing the resident from her room to the assist dining room.</p> <p>During an interview on 10/30/14 at 1:20 p.m., CNA # 4 indicated she checked and changed her incontinent residents every two hours. She indicated she had</p>			

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F000312 SS=D	<p>checked and changed Resident # 6's brief last on 10/30/14 at 11:15 a.m.</p> <p>During an interview on 10/31/14 at 4:15 p.m., the ADHS (Assistant Director of Health Services) indicated Resident # 6 should have been checked and changed every two hours.</p> <p>483.25(a)(3) 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. Based on observation, interview and record review, the facility failed to provide toileting assistance in a timely fashion to 2 of 2 residents reviewed for urinary incontinence. (Residents #6 and #98).</p> <p>Findings include:</p> <p>1. On 10/30/14 at 9:43 a.m., Resident # 6's record was reviewed. Diagnoses included, but were not limited to, stroke with right hemiplegia (one sided paralysis), expressive aphasia (inability to communicate verbally), depressive disorder, dementia, chronic kidney disease and renal failure II.</p> <p>The resident's admission MDS</p>	F000312	<p><u>F312</u></p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p>	12/05/2014

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	<p>(Minimum Data Set) assessment dated 10/3/14 indicated her functional status for toilet use was an extensive assist with a two person physical assist. She required an extensive assist and one person physical assist for personal hygiene. The resident always had urinary incontinence.</p> <p>The Elimination Plan of Care included, but was not limited to, "9/22/14--...Check and change incontinence product q [every] shift q 2 hours + [and] prn [as needed]...."</p> <p>These observations were made on the following dates and times: On 10/27/14 at 2:46 p.m., there was a strong urine odor in the resident's room during a resident interview.</p> <p>On 10/28/14 at 9:43 a.m., there was a strong urine odor while standing next to the resident in the TV lounge.</p> <p>During a continuous observation of the resident on 10/30/14 from 9:26 a.m., to 1:30 p.m., the resident was not observed to be checked for incontinence or her brief was not changed.</p> <p>On 10/30/14, at the following times the resident was observed in the Pioneer Way lounge sitting in her broda chair watching TV.</p>		<p><i>In response to the cited findings</i></p> <p><i>R/T to F312, the following</i></p> <p><i>Actions will be taken:</i></p> <p>A) With respect to these findings,</p> <p><i>Resident #6 checked upon rising,</i></p> <p><i>before/after meals, before bed and PRN,</i></p> <p><i>lift required for transfers</i></p> <p><i>per care plan. Resident# 98 assure toileting as requested/as needed</i></p> <p><i>per care plan. All 50 of the 50 residents</i></p> <p><i>in the skilled nursing unit in the Health Care Center had the potential to be affected</i></p> <p><i>by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will</p> <p>identify residents with the potential</p>	

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	<p>At 9:26 a.m., 10:40 a.m., and 11:40 a.m. At 11:45 a.m., she was observed to have a urine odor while standing next to her.</p> <p>On 10/30/14 at 11:50 a.m., the resident was taken from the Pioneer Way TV lounge to the assist dining room.</p> <p>On 10/30/14 at 1:00 p.m., the resident was brought from the assist dining room to the Pioneer Way TV lounge and placed in front of the TV.</p> <p>On 10/30/14 at 1:13 p.m., CNA # 4 was observed asking Resident # 6 if she wanted to lay down and watch TV in her room. The resident indicated at that time she did not want to lay down. CNA # 4 was observed moving the resident's broda chair in front of the TV.</p> <p>On 10/30/14 at 1:30 p.m., CNA # 4 and CNA # 5 were observed transferring Resident # 6 to bed. While the resident was laying in bed, before her pants and brief were removed, a strong urine odor was detected. CNA # 4 and CNA # 5 were observed providing pericare for the resident and placing a new brief on her. When the brief that was moderately saturated with amber colored urine was removed from the resident, there were indentation lines observed on the resident's buttocks and her inner groin</p>		<p>for the identified concern and take</p> <p>corrective action: <i>Nursing Leadership</i></p> <p><i>will monitor during hourly rounding</i></p> <p><i>to observe for any concerns</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern:</p> <p><i>DHS and/or designee will in-service all nursing staff on ADL care related to incontinence per campus policy and procedures.</i></p> <p>D) With respect to how the plan of corrective measures will be monitored:</p> <p><i>DHS and/or designee will do random 1 time per weekly checks ADL/ incontinence care for 3 month with the results of the audit</i></p>	

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	<p>areas. A very strong urine odor was detected .</p> <p>During a continuous observation of the resident on 10/31/14 from 8:45 a.m., to 11:50 a.m., there were no observations of the resident being checked or changed every two hours.</p> <p>On 10/31/14 at 8:45 a.m., the resident was observed to be taken to her room and placed in bed and incontinence care given.</p> <p>On 10/31/14 at 10:37 a.m., the resident remained in bed and CNA # 4, who was her CNA left the unit for her lunch break.</p> <p>On 10/31/14 at 11:08 a.m., the resident remained in bed.</p> <p>On 10/31/14 at 11:18 a.m., CNA # 4 returned to the unit.</p> <p>On 10/31/14 at 11:25 a.m., CNA # 4 and RN # 2 attempted to assist the resident up for lunch and she refused to get up for lunch, so both staff members left the resident's room.</p> <p>On 10/31/14 at 11:50 a.m., an unidentified CNA was observed pushing the resident from her room to the assist dining room.</p>		<p><i>observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation.</i></p> <p>E) Date of compliance with proposed actions: 12/05/14</p>	

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	<p>During an interview on 10/30/14 at 1:20 p.m., CNA # 4 indicated she checked and changed her incontinent residents every two hours. She indicated she had checked and changed Resident # 6's brief last on 10/30/14 at 11:15 a.m.</p> <p>During an interview on 10/31/14 at 4:15 p.m., the ADHS (Assistant Director of Health Services) indicated Resident # 6 should have been checked and changed every two hours.</p> <p>2. On 10/31/14 at 9:30 a.m., the record review for Resident #98 was completed. Diagnoses included, but were not limited to, Alzheimer's, macular degeneration, and a history of urinary tract infections.</p> <p>The admission assessment dated 9/16/14 indicated, "...Bladder, always continent..."</p> <p>The MDS (Minimum Data Set) Assessment dated 9/27/14 indicated the resident had occasional episodes of incontinence.</p> <p>On 10/31/14 at 2:00 p.m., the ADHS provided an undated document titled, "CORP- Individual Plan Report", which she indicated was the care plan. The document indicated, "...BOWEL AND</p>			

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F000323 SS=D	<p>BLADDER Admission date: 9/16/14 : I know when I have to go to the bathroom, but can not always get there in time. My goal is to not be incontinent as much as possible. Please assist me to the bathroom upon arising, before and after meals, and as as [sic] needed"</p> <p>On 10/29/2014 10:02 a.m., during an observation, the resident was observed to be in her recliner, there was a mild urine odor noted in the room .</p> <p>The documentation for ADL (Activity of Daily Living) 10/29/14 the resident was toileted at the following times: 2:46 a.m., 11:26 a.m., and 10:08 p.m.</p> <p>On 10/31/14 at 11:20 a.m., Assistant Director of Health Services (ADHS) indicated she questioned the admission assessment which indicated the resident was continent of bladder upon admission, she indicated the family had given this information, and was unsure of the validity. She indicated the resident can tell people she needs to use the restroom and sometimes she forgets.</p> <p>3.1-38(3)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>			

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	<p>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 follow accident prevention interventions for 2 of 6 residents reviewed for accidents. (Resident #37 and #6).</p> <p>Findings include:</p> <p>1. Resident #37's record was reviewed on 10/30/2014 at 10:46 a.m. Diagnoses, included but were not limited to, dementia, legal blindness, and a history of falls.</p> <p>The resident's record indicated the resident had falls on 7/20, 7/21, 7/27, 7/28, 8/2, 8/3, 8/5, 8/14, 8/20, 9/6, 9/9, 10/15 and 10/22/2014.</p> <p>During an observation on 11/3/2014 at 11:45 a.m., Resident #37 was observed unattended and reaching down trying to adjust his Velcro shoe strap.</p> <p>During an observation and interview on 11/3/2014 at 12:10 p.m., with LPN # 7, the resident's safety chair alarm clip was observed attached to the back of his wheelchair. At this time LPN #7, indicated the alarm clip should be</p>	F000323	<p>F323</p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings</i></p> <p><i>R/T to F323, the following</i></p> <p><i>Actions will be taken:</i></p> <p>A) With respect to these findings, Resident #6 PSA attached per care plan. Resident# 37 assure</p>	12/05/2014
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	<p>attached to the resident.</p> <p>The resident's current, "...Individual Plan Report" indicated the following: "...Place a PSA [personal safety alarm] on my bed /chair ... to remind me to ask for assist with transfers and to alert you if I don't... Resident not to be left alson [sic] in room...."</p> <p>During a transfer observation on 10/31/14 at 10:45 a.m., Resident #37 was observed being transferred by CNA #8 and LPN #9 from a straight back chair to his wheelchair. CNA #8's first attempted to transfer the resident by having him give her a "bear hug" by having the resident place his arms around her neck as she wrapped her arms around his waist. She attempted to lift the resident out of the straight back chair but was unable to hold him up. She had to sit him back down into the chair. She went and got assistance from LPN #9 to perform the transfer.</p> <p>At that point CNA #8 placed her left arm under his arm and LPN #9 placed her right arm under his right arm and the resident was lifted up and into his wheelchair. Once in his wheel chair the CNA and LPN placed an arm under his arm and thigh and lifted him up to raise him up in his wheelchair. No gait belt was</p>		<p><i>transferred according to campus policy and procedures. All 50 of the 50 residents in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action: <i>Nursing Leadership will monitor during hourly rounding to observe for any concerns</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>DHS and/or designee will in-service all nursing staff on transfers and proper</i></p>	

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	<p>observed being used during the transfer.</p> <p>During an interview on 10/31/2014 at 11:04 a.m., CNA #8 indicated the resident was normally a one person transfer but for some reason he would not stand up today. She indicated she should have used a gait belt on the resident to transfer him but she did not have a gait belt with her because she had forgotten it.</p> <p>During an interview on 11/3/14 at 12:58 p.m., the ADHS (Assistant Director of Heath Services) indicated CNA #8 and LPN #9 should have used a gait belt to safely transfer the resident.</p> <p>The facility's, "Body Mechanics and Transfers" was reviewed on 11/3/14 at 1:00 p.m., and indicated, "Rules for Transferring ... Lean the resident's shoulders toward you. Hold on to the gait belt... If the resident is heavy, get help... Count to three out loud so the resident will be prepared for the transfer. At the count of three lift and transfer the resident... How to protect yourself while transferring... Hold the resident close to you... Do not let the resident hold you around your neck during the transfer...."</p> <p>2. On 10/30/14 at 9:43 a.m., Resident # 6's record was reviewed. Diagnoses included, but were not limited to, stroke with right hemiplegia (one sided</p>		<p><i>use of gait belts per campus policy and procedures</i></p> <p>D) With respect to how the plan of corrective measures will be monitored: DHS and/or designee will observe transfers and proper us of gait belts 2 time per weekly for 3 month with the results of the audit observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation.</p> <p>E) Date of compliance with proposed actions: 12/05/14</p>	

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	<p>paralysis), expressive aphasia (inability to communicate verbally), dementia, contracture of the right hand and right knee and osteoarthritis.</p> <p>The resident's admission MDS (Minimum Data Set) assessment dated 10/3/14, indicated: The resident's functional status indicated her transfers required an extensive assist with a two person physical assist.</p> <p>A Physician's progress note dated 10/9/14, indicated the resident had a stroke and she had right hemiplegia. She had decreased range of motion to her right lower extremity and a contracture of her right hand.</p> <p>A document titled "CORP [Care of Resident Profile]-Individual Plan Report" dated 10/31/14, indicated "ACUTE CARE NEEDS: ...9/23/14-I have had a stroke. I have severe right sided hemiplegia. I am non-weightbearing and require the assist of 2 people to transfer with the Maxi-Lift... 9/23/14-Falls: I am at risk for falls r/t [related/to] right sided weakness and decreased mobility. Place my bed at an appropriate level for my body height to facilitate safe transfers...."</p> <p>During an observation on 10/30/14 at 1:30 p.m., CNA # 4 and CNA # 5</p>			

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	<p>transferred the resident to bed by placing a gait belt around the resident's waist while she was in the broda chair. Each CNA had one arm under each one of her arms and lifted her out of her broda chair and placed her into her bed by holding onto the gait belt while lifting the resident.</p> <p>During an interview on 10/31/14 at 4:15 p.m., the ADHS (Assistant Director of Health Services) indicated the CORP-Individual Plan Report was located on the "Caretracker" computer system and the CNA's used the information from that report to provide care for the resident's instead of a CNA assignment sheet. She indicated Resident # 6's CORP-Individual Plan Report indicated she was to be transferred with a mechanical lift, but she did not know if the staff used the lift to transfer her. She indicated she would have to check into whether the resident was to be transferred with the mechanical lift and provide that information.</p> <p>During an interview on 11/3/14 at 12:58 p.m., the ADHS indicated Resident # 6 was to be transferred by a mechanical lift to safely transfer the resident</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to monitor for specific behaviors to support the use of an antipsychotic medication, this included no diagnosis for the use of an antipsychotic for 1 of 5 residents reviewed for unnecessary medications. (Resident #70)</p> <p>Findings included:</p> <p>On 10/28/2014 1:18 p.m., the record review was completed for Resident #70.</p>	F000329	<p>F329</p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as</p>	11/25/2014

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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060
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	<p>Diagnoses included, but were not limited to, dementia and depression.</p> <p>The physician's order recapitulation for October 2014, indicated the resident was receiving Risperidone (an antipsychotic medication) 0.5 milligrams for dementia since 7/3/14.</p> <p>On 10/31/14 at 10 a.m., a request was made to The Social Services Director (SSD) for the diagnosis for use of Risperdal, as well as the monitoring of the behavior tracking to support the use of the medication.</p> <p>The documentation titled, "CORP-Behavior Detailed Entry Report" indicated behaviors on the following dates: 7/3/14 -11:15 p.m., Socially inappropriate behavior/other. 7/7/14 - 12:00 p.m., Socially inappropriate behavior/other. 7/8/14- 11:30 p.m., Socially inappropriate behavior/other. 7/9/14- 9:15 a.m., Resists care 7/9/14- 5:30 p.m., Physically abusive 7/12/14- 11:45 p.m., Socially inappropriate behavior/other. 9/4/14- 5:45 p.m., wandering 9/13/14- 5:30 p.m., wandering</p> <p>On 10/31/14 at 1:05 p.m., SSD indicated</p>		<p>a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings R/T to F329, the following Actions will be taken:</i></p> <p>A) With respect to these findings, <i>Social Services and the Nursing Department will review medications for those resident's with a diagnosis of dementia with behaviors. Antipsychotic usage will be discontinued for those not exhibiting active s/sx of psychosis.</i></p> <p>B) With respect to how the facility will identify residents with the potential for the identified concern and take corrective action: <i>SS and Nursing to obtain</i></p>	

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	<p>the resident was on Risperidone for depression with psychiatric behaviors and psychotic behaviors. The SSD indicated the resident had been hallucinating on 10/2/14 about seeing children and the people eyes being pink.</p> <p>On 11/3/14 at 10:14 a.m., the SSD indicated that the residents diagnosis for the use of the Risperidone was dementia with behaviors and was admitted to the facility on the medication. She indicated the resident had a urinary tract infection she was seeing people with the pink eyes and children running around, The SSD indicated there was not enough information provided on the behavior tracking tool to identify what hallucination or delusions the resident had or how "Socially inappropriate behavior/other" exhibited for the resident.</p> <p>On 11/3/14 at 9:30 a.m.,CNA # 5 indicated they have several options to choose from when documenting behaviors for a resident. The CNA's were to choose them most appropriate behavior for what they were observing and document what happened in the computer system.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>		<p><i>medication lists from pharmacy and cross</i></p> <p><i>reference diagnoses with the medical record/ICD-9 codes.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern:</p> <p><i>SS and nursing to evaluate at the time</i></p> <p><i>of the medication order from the MD if</i></p> <p><i>an alternative medication or intervention</i></p> <p><i>is appropriate for the resident.</i></p> <p><i>Those residents</i></p> <p><i>with diagnoses of "dementia with behaviors"</i></p> <p><i>will be monitored by the behavior team</i></p> <p><i>consisting of; the MD, Registered Pharmacist, Director of Health Services, Director</i></p> <p><i>of Social Services, and Unit</i></p>	

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F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.		<p><i>Managers.</i></p> <p><i>New orders will be discussed as an IDT following</i></p> <p><i>the recommendation of the order.</i></p> <p>D) With respect to how the plan of corrective measures will be monitored:</p> <p><i>Social Services and Nursing will review</i></p> <p><i>the antipsychotic medication usage in the</i></p> <p><i>weekly "Clinically at Risk" Meeting. The IDT</i></p> <p><i>will discuss alternative medications/ interventions for the resident.</i></p> <p>E) Date of compliance with proposed actions: November 25, 2014.</p>	

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	<p>o The current date.</p> <p>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure timely posting of nursing staff information for 2 of 6 days observed during the annual survey. This deficient practice has the potential to impact 50 of 50 residents residing in the facility. (October 27 and 29, 2014)</p> <p>Findings include:</p>	F000356	<p>F356</p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of</p>	11/25/2014

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	<p>During the initial tour observation on 10/27/2014, at 10:00 a.m., the posted "Today's Staffing" report was dated and included information for 10/24/14.</p> <p>During an observation on 10/29/2014 at 9:31 a.m., the posted "Today's Staffing" report was dated and included information for 10/28/2014.</p> <p>During an interview on 10/29/14 at 9:31 a.m., the Minimum Data Set (MDS) Coordinator indicated the correct nursing staffing report should be posted that morning when the Scheduler came into work at 11:00 a.m.</p> <p>During an interview on 10/29/14 at 9:35 a.m., RN # 1 indicated the Scheduler would not be in that morning. She indicated she was not sure who was responsible for posting the nursing staffing report when the Scheduler was not at the facility, but she would find out.</p> <p>During an interview on 10/29/14 at 9:40 a.m., the ADHS (Assistant Director of Health Services) indicated she was responsible for posting the nursing staffing report when the Scheduler was not in the facility. She indicated she had been trying since 5:30 a.m., that morning to print a copy of the nursing staffing report to post, but she was unable to get a</p>		<p>Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings R/T to F356, the following Actions will be taken:</i></p> <p>A) With respect to these findings, <i>All 50 of the 50 residents in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action: <i>All 50 of the 50 residents</i></p>	

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	<p>copy to print. She indicated writing the report out was an option she could have done and she would do it if she could not get the report to print this time. She indicated the MOD (Manager on Duty) was responsible for posting the nursing staffing report on the weekends, but there was a new Maintenance manager on duty this past weekend. ADHS indicated the Maintenance Manager did not know he had to pull the nursing staffing report from the book and post it daily and that was the reason the 10/24/14 nursing staffing report was posted on 10/27/14 on the initial tour.</p> <p>3.1-13(g)(4)</p>		<p><i>in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>Per policy the facility must post the nursing staffing data on a daily bases at the beginning of each day. Manager on Duty will be assigned to posting nursing staffing data at the beginning of their shift for that day. (Saturday & Sunday)</i></p> <p>D) With respect to how the plan of corrective measures will be monitored: <i>The DHS or designee will audit posting</i></p>	

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to use sanitary practice while preparing food and in maintaining food storage areas in a	F000371	1 time per week for 3 months with the results of the audit observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation. E) Date of compliance with proposed actions: November 25, 2014 <u>F371</u> Responses to the cited findings	12/05/2014

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	<p>clean and sanitary condition. This deficient practice had the potential to affect all 50 residents currently residing in the facility.</p> <p>Findings included:</p> <p>On 10/27/14 at 9:40 a.m., the kitchen tour was completed with the Dietary Services Manager (DSM).</p> <p>The walk in refrigerator was observed to have a pool of dried debris on the floor in the far right corner. There were 8 pieces of spaghetti squash cut up and face down on a piece of wax paper, lying on a tray on the middle shelf of the walk in refrigerator, they were not covered. The DSM indicated they should have been covered. The refrigerator had pork loin dated 10/19/14, he indicated that should have been thrown away. He indicated they clean out the refrigerators on Mondays.</p> <p>The ice machine was observed to have black slimy debris inside of the machine right above where the ice was stored. The DSM wiped his gloved finger along the edge and a black slimy substance came off onto the finger of his glove. He indicated at that time during interview, he wasn't sure who cleaned it, but he thought it was done monthly.</p>		<p>do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings R/T to F371, the following Actions will be taken:</i></p> <p>A) With respect to these findings, Debris in walk in refrigerator on floor removed. Food items covered and/or thrown out per campus policy and procedures. Ice machine and oven cleaned accordingly. <i>All 50 of the 50 residents in the skilled nursing unit in</i></p>	

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	<p>There were 2 ovens that were used according to the DSM, and 1 of 2 ovens had thick black debris on the bottom of the oven. The DSM indicated at that time during interview, the ovens were cleaned weekly.</p> <p>A document titled, "Weekly Cleaning List" indicated, "...Cleaning task Clean/organize walk in dated 10/19/14 and signed with initials...Saturday...clean ovens...dated 10/20/14 and signed with initials...."</p> <p>During an observation on 10/27/2014 at 11:57 a.m., Cook #11 had the same pair of gloves on while she performed the following preparation for the lunch meal: she touched the handle on the sink, touched and wiped her pant leg, and then pulled up her pants. She then touched a cooked hot dog and put it onto a bun for a resident to eat. She then touched a handle on a drawer, picked a lettuce leaf and placed it onto a bun for a hamburger for a resident. She then touched the cooked pork loin, to slice it up.</p> <p>She then took off her gloves and hand washed for 5 seconds and donned a new pair of gloves. After placing the new pair of gloves on, she continued touching drawer handles, scoops inside of the</p>		<p><i>the Health Care Center had</i></p> <p><i>the potential to be affected</i></p> <p><i>by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action: <i>Director of Food Service to trust but verify that weekly cleaning lists are completed to satisfaction.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>Director of Food Service and/or designee to in-service staff on weekly cleaning schedules, proper cleaning techniques, and proper</i></p>	

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	<p>drawers, visibly soiled potholders and oven mitts, cooked meat, bread, and touched the microwave handle as she microwaved the french fries and chicken fingers which she then took with the same gloved hands and placed onto plates for residents to eat.</p> <p>During an observation of the DSM on 10/27/2014 at 12:07 p.m., he used the same gloves while going out to the dining room, then touched handles on the drink refrigerator, handle on the sink by food prep area and then touched blueberries and strawberries with the same gloves.</p> <p>On 10/27/14 at 12:10 p.m., an observation was made of a document hanging on the wall above 1 of 2 hand washing sinks which indicated, "... wash your hands for at least 20 seconds with hot water. when serving food, wash your hands every 3rd pass and hand sanitize every pass..." The DSM indicated at that time, this was their policy for hand washing.</p> <p>3.1-21(i)(3)</p>		<p><i>sanitation according to the campus policies and procedures.</i></p> <p>D) With respect to how the plan of corrective measures will be monitored:</p> <p><i>The Director of Food Service or designee will audit cleaning schedules 2 time per week for 3 months with the results of the audit observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation</i></p> <p>E) Date of compliance with proposed actions: 12/05/14</p>	

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure medications were properly stored in 2 out of 3 medication rooms in the facility being observed for</p>	F000431	<p><u>F431</u></p> <p>Responses to the cited findings</p>	12/05/2014

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	<p>secured medications. (Pioneer Way and Noble Lane medication rooms)</p> <p>Findings include:</p> <p>On 10/30/14 at 5:35 p.m., during a medication room storage observation in the Pioneer Way unit medication room, there was no zip tie observed on the Insulin EDK (Emergency Drug Kit) located in the medication refrigerator to ensure it was closed.</p> <p>During an interview at that time, RN # 2 indicated he did not know the Insulin EDK had to have a zip tie on it to ensure it was closed. He indicated he did not know when it had been opened, but he would order a new one to be delivered tonight. He placed a black zip tie on the EDK box at that time.</p> <p>On 10/30/14 at 5:41 p.m., during a medication room storage observation in the Noble Lane unit medication room, there were no zip tie observed on the top or bottom portion of the PO (by mouth) EDK box.</p> <p>During an interview at that time, LPN # 3 indicated the EDK box should have had two zip ties on it. She indicated there should have been one on the top and bottom portion of the box. She placed a</p>		<p>do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings R/T to F431, the following Actions will be taken:</i></p> <p>A) With respect to these findings, All EDK's checked or replaced zip ties.</p> <p>All 50 of the 50 residents in the skilled nursing unit in the Health Care Center had the potential to be affected by this alleged deficient practice.</p>	

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	<p>black zip tie on the top and bottom portion of the box at that time.</p> <p>During an interview on 11/3/14 at 3:20 p.m., RN # 1 indicated when an EDK box was opened, the nurse would fill out a carbon copy sheet inside the box and apply a zip tie to secure the box closed.</p> <p>3.1-25(m)</p>		<p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action: <i>Nursing Leadership will monitor during daily rounding to assure ties are in place.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>DHS and/or designee will in-service all nursing staff on proper EDK usage, storage and safety.</i></p> <p>D) With respect to how the plan of corrective measures will be monitored: <i>The DHS or designee will monitor all EDK's on all halls 2 time per week</i></p>	

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5	R000000	<p><i>for 3 months with</i></p> <p><i>the results of the audit</i></p> <p><i>observations reported, reviewed</i></p> <p><i>and trended for compliance</i></p> <p><i>thru the campus Quality Assurance Committee</i></p> <p><i>for a minimum of 3 months</i></p> <p><i>then randomly thereafter</i></p> <p><i>for further recommendation.</i></p> <p>E) Date of compliance with proposed actions: 12/05/14</p>	
R000154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from			

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	<p>litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and record review, the facility failed to maintain the kitchen area in a clean and sanitary manner. This deficient practice had the potential to affect all 48 residents currently residing in the assisted living area of the facility.</p> <p>Findings included:</p> <p>On 11/3/14 at 4:00 p.m., an observation of the kitchen on the Legacy unit was made with the Residential Director of the Legacy unit present. The dietary staff for that area was not available.</p> <p>There was a container of potato salad dated 10/28/14 observed in the refrigerator.</p> <p>The dry storage area had a large amount of debris underneath of the racks on the floor.</p> <p>There was a can of pitted prunes dated 12/17, that had a large dent in it.</p> <p>The drink station on the bottom shelf had a large puddle of dried white matter on it.</p> <p>A document dated 9/2012, titled "Leftover Food Storage" indicated, "...2. Date all food and use or discard within</p>	R000154	<p>R154</p> <p>Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p> <p><i>In response to the cited findings</i></p> <p><i>R/T to R154, the following</i></p> <p><i>Actions will be taken:</i></p> <p>A) With respect to these findings,</p> <p><i>Potato Salad was immediately disgarded,</i></p> <p><i>Debris swept, drinking station shelf cleaned, dented prunes disgarded.</i></p>	12/05/2014

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	<p>three days...27....damaged, dented cans are not used. If any can has bulges, leaks, bad odor or off color, it is not used. It is set aside and marked "not to use" until returned to vendor...."</p> <p>A document titled, " Weekly Cleaning List" indicated, "...Wednesday...Clean/organize dry storage (N)..." the space with task under date and initials was blank. The rest of the cleaning list had dates and initials of 10/2, 10/3, and 10/4.</p>		<p><i>All residents residing in the Legacy Building had potential to be affected by this alleged deficient practice.</i></p> <p>B) With respect to how to facility will identify residents with the potential for the identified concern and take corrective action: <i>DSM to trust but verify that weekly cleaning lists are completed to satisfaction.</i></p> <p>C) With respect to what systematic measures have been put into place to address the stated concern: <i>DSM and/or designee to in-service staff on weekly cleaning schedules, proper cleaning techniques, proper sanitation and dented cans according</i></p>	

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			<p><i>to the campus policies and procedures.</i></p> <p>D) With respect to how the plan of corrective measures will be monitored:</p> <p><i>The DSM or designee will audit cleaning schedules 2 time per week for 3 months with the results of the audit observations reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 3 months then randomly thereafter for further recommendation</i></p> <p>E) Date of compliance with proposed actions: 12/05/14</p>	

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

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FORM APPROVED

OMB NO. 0938-0391

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