

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2016
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NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: April 25, 26, 27, 28, 29, 2016</p> <p>Facility number: 011596 Provider number: 155769 AIM number: 200901690</p> <p>Census bed type: SNF/NF:33 SNF:19 NF:0 Residential:36 Total:88</p> <p>Census payor type: Medicare: 30 Medicaid: 6 Other: 52 Total: 88</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. in regard to the Recertification and State Licensure Survey.</p> <p>QR completed by 11474 on May 6, 2016.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on April 29, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to notify</p>	F 0157	F 157 Corrective actions accomplished for those residents found to be affected	05/23/2016

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	<p>the physician of significant changes to a resident's condition for 1 of 5 residents regarding weight gain and medication adverse events, whose records were reviewed for unnecessary medications (Resident #1). The facility also failed to notify the physician of a change in medication administration time regarding insulin for 1 of 5 residents whose medications were reviewed for unnecessary medications (Resident #40).</p> <p>Findings include:</p> <p>1. A review of the medical record for Resident #1 was completed on 4/25/2016 at 10:46 a.m. Her diagnoses included but were not limited to diabetes mellitus, heart failure, anemia, chronic atrial fibrillation and edema. The quarterly, 3/18/16, Minimum Data Set assessment indicated Resident #1 was moderately cognitively impaired.</p> <p>Physician orders for Resident #1 were dated 4/1/2016-4/28/2016 and indicated "Daily Weights Special instructions: notify MD of weight gain of more than 2 lbs in 24 hours Once a day; 06:00 AM-10:00 AM" with a start date of 2/17/2016.</p> <p>A care plan with the problem "I take a diuretic, due to my DX [diagnosis] of HF</p>		<p>by the alleged deficient practice: Resident #1 MD will be notified of significant changes regarding weight gain and any medication adverse events. Resident #40 MD will be notified of the resident request for a change in medication administration time for insulin.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will notify MD of significant changes regarding weight gain and any medication adverse events. DHS or designee will notify MD of residents request for a change in medication administration time for insulin.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the licensed nurses on the following guideline: 1 Anticoagulant assessment. 2 Weight tracking. 3 MD notification. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1 MD is notified of significant changes regarding weight gain and any medication</p>				

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	<p>[heart failure]...." Interventions included "...I would like staff to check my weight per MD [Medical Doctor] orders and to notify my doctor of any significant changes."</p> <p>The "Vitals Report" containing weights for Resident #1, provided by Nurse Consultant #8 on 4/28/2016 at 2:30 p.m., indicated the following:</p> <p>On 2/20/2016 at 12:34 p.m. she weighed 208 lbs, on 2/20/2016 at 1:18 p.m. she weighed 238 lbs (30 lbs gain).</p> <p>On 2/23/2016 she weighed 233 lbs and on 2/24/2016 she weighed 239 lbs (6 lbs gain)</p> <p>On 2/25/2016 she weighed 236 lbs and on 2/26/2016 she weighed 240 lbs (4 lbs gain).</p> <p>On 2/28/2016 she weighed 236.8 lbs and on 2/29/2016 she weighed 242.2 lbs (5.4 lbs gain).</p> <p>On 3/4/2016 she weighed 241 lbs and on 3/5/2016 she weighed 243.2 lbs (2.2 lbs gain).</p> <p>On 3/14/2016 she weighed 222.4 lbs. and on 3/15/2016 she weighed 224.8 lbs (2.4 lbs gain).</p>		<p>adverse events. 2 MD is notified of residents request for a change in medication administration time for insulin. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>On 3/15/2016 she weighed 224.8 lbs and on 3/16/2016 she weighed 227 lbs (2.2 lbs gain).</p> <p>On 3/26/2016 she weighed 193.4 lbs and on 3/27/2016 she weighed 196.4 lbs (3 lbs gain).</p> <p>On 3/27/2016 she weighed 196.4 lbs and on 3/28/2016 she weighed 218.8 lbs (22.4 lbs gain).</p> <p>On 3/29/2016 she weighed 214.4 lbs and on 3/30/2016 she weighed 231.8 lbs (17.4 lbs gain).</p> <p>On 3/31/2016 she weighed 213.2 lbs and on 4/1/2016 she weighed 219.2 lbs (6 lbs gain)</p> <p>On 4/8/2016 she weighed 217.5 lbs and on 4/9/2016 she weighed 219.6 lbs (2.1 lbs gain).</p> <p>On 4/10/2016 she weighed 219.6 lbs and on 4/11/2016 she weighed 222.2 lbs (3.2 lbs gain).</p> <p>On 4/13/2016 she weighed 215.8 lbs and on 4/14/2016 she weighed 219.4 lbs (2.6 lbs gain).</p> <p>On 4/14/2016 she weighed 219.4 and on</p>			

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	<p>4/15/2016 she weighed 223 lbs (3.6 lbs gain).</p> <p>On 4/17/2016 she weighed 220.8 lbs and on 4/18/2016 she weighed 224.2 lbs (3.4 lbs gain).</p> <p>On 4/27/2016 she weighed 221.6 lbs and on 4/28/2016 she weighed 226.6 lbs (5 lbs gain).</p> <p>During an interview with the Assistant Director of Health Services (ADHS), on 4/28/2016 at 10:53 a.m., she indicated LPN #7 was working on printing off the physician notification for Resident #1's change in weight.</p> <p>During an interview with LPN #7 on 4/28/2016 at 10:55 a.m., she indicated she had not been able to locate any documentation to show the doctor had been notified regarding Resident #1's weight gains.</p> <p>Physician orders for Resident #1 were dated 4/1/2016-4/28/2016 and indicated Eliquis (anticoagulant) 2.5 mg twice a day, with a start date of 2/16/2016.</p> <p>A care plan with the problem "High Risk Medications" last updated on 4/28/2016 indicated the resident has been "placed on an anti-coagulant for A-fib [atrial</p>			

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	<p>fibrillation]. This places me at risk for increased bleeding." Interventions included but were not limited to "I want staff to notify my nurse if they notice that I have bleeding gums, nose bleeds, unusual bruising, tarry/black stools...."</p> <p>The "Vitals Report" containing the bowel record for Resident #1 was provided by LPN #7 on 4/28/2016 at 2:21 p.m. It indicated the following:</p> <p>On 2/1/2016 a black and tarry bowel movement was documented</p> <p>On 3/14/2016 a black and tarry bowel movement was documented</p> <p>On 3/21/2016 a black and tarry bowel movement was documented</p> <p>On 3/23/2016 a black and tarry bowel movement was documented</p> <p>On 3/27/2016 a black and tarry bowel movement was documented</p> <p>During an interview with LPN #4 on 4/29/2016 at 9:32 a.m., she indicated she monitored Resident #1 for sign and symptoms of bleeding that included bruising, redness, warmth, shortness of breath and black stools. She indicated that she would notify the doctor if she</p>			

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	<p>observed any of the signs or symptoms. LPN #4 indicated that since Eliquis was a newer drug and and because there was no testing done, such as regular lab work like some of the other anticoagulant medications, she would notify the physician immediately.</p> <p>During an interview with the ADHS on 4/29/2016 at 9:44 a.m., she indicated nursing normally monitored a resident who was on anticoagulation therapy. She indicated that black tarry stools was a sign of bleeding and the nursing staff should have called the physician if that was noticed.</p> <p>A policy titled "Anti-Coagulant Assessment Guideline" was provided by Nurse Consultant #8 on 4/29/2016 at 8:32 a.m. It indicated "Purpose: to provide guidelines for monitoring residents on anticoagulant therapy. Procedure: 1. Each resident receiving Anticoagulant drug therapy will be monitored."</p> <p>2. A review of the medical record for Resident #40 was completed on 4/26/2016 at 1:30 p.m. His diagnosis included, but were not limited to, diabetes mellitus with hyperglycemia.</p> <p>A review of the current physician orders</p>			

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	<p>for Resident #40, dated 9/28/2015 indicated "Novolog Flex Pen (Insulin Aspart) insulin pen; 100 unit/mL; amt: 2 units; subcutaneous Before Meals;...."</p> <p>During an observation of medication administration for Resident #40 on 4/26/2016 at 1:19 p.m., LPN #9 administered 2 units of Novolog. She indicated Resident #40 had already eaten lunch and that he "always" received his insulin after he ate.</p> <p>During an interview with LPN #2 on 4/28/2016 at 9:05 a.m., she indicated Resident #40 "always" took insulin after he ate lunch. She indicated that she knew the order was to give the insulin prior to meals. She had not notified the physician of the resident's request to take his insulin after his meals.</p> <p>During an interview with LPN #7 on 4/28/2016 at 10:40 a.m., she indicated they could not locate any documentation that the physician had been notified of Resident #40 receiving his insulin after his meals.</p> <p>No further documentation was provided prior to the time of exit.</p> <p>3.1-2 3.1-5(a)</p>			

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F 0159 SS=B Bldg. 00	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>			

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	<p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure residents were aware of a method to obtain money from residents' personal trusts funds on weekends for 2 of 2 residents who met the criteria for residents funds review. The deficient practice had the potential to impact 5 of 5 residents who maintained funds in a resident's trust account. (Resident # 1 and 33)</p> <p>Findings include:</p> <p>During a 4/26/16, 2:24 p.m., interview, Resident #1 indicated resident trust money was not available on weekends because a resident could not get money if the business office was closed.</p> <p>During a 4/26/16, 9:50 am, Resident #33 indicated resident trust money was not available on weekends because the office</p>	F 0159	<p>F 159 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #1 and #33 were made aware of the method to obtain money from the resident's personal trust fund after business hours and on the weekends. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus staff on the following guideline:1 Method for residents to obtain money from their personal trust fund after buisness hours and on the weekend. 2</p>	05/23/2016

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	<p>was not open on weekends.</p> <p>During a 4/27/16, 9:47 a.m., observation, the business office had no resident trusts banking hours posted either inside or outside of the office. Banking hours were not found posted anywhere in the facility.</p> <p>During a 4/28/16, 8:55 a.m. interview, the Business Office Manager indicated the business office was open Monday through Friday 8:00 a.m. to 5:00 p.m. with the exception of Wednesday which was open until 6:00 p.m. She additionally indicated resident funds money was available on weekends in the medication cart on the assisted living area of the facility. When questioned how residents were informed of the available weekend money, she indicated she did not know how they were informed. When questioned if she provided this information at the time residents sign up for resident funds account, she indicated she did not. The Business Office Manager additionally indicated nurses should have been aware. Lastly she indicated the facility managed residents' personal funds account for 5 residents who resided in the health care area of the facility.</p> <p>During a 4/28/16, 9:02 a.m., interview,</p>		<p>Resident council will be held to notify of the method to obtain money from the resident's personal trust fund after business hours and on the weekends. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following interviews for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents are aware of the method to obtain money from the resident's personal trust fund after business hour and on the weekends. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>LPN #21 indicated she did work weekends. She indicated she was unaware of how resident funds were made available on weekends. She indicated she would have to contact the "On-Call" nurse for guidance.</p> <p>During a 4/28/16, 9:05 a.m., interview, LPN #22 indicated she worked weekends. She indicated she did not know if resident funds were available on weekends. She indicated she would call Social Services or the Nurse on-call for assistance.</p> <p>During a 4/28/16, 9:08 a.m., interview, LPN #23 indicated she served as an on-call nurse and sometimes covered weekends. She indicated she did not know and had not been trained how residents could obtain money from their resident's personal funds account on weekends. She indicated she would contact the Director of Nursing or Administrator for assistance.</p> <p>During a 4/28/16, 9:09 a.m., interview, LPN #24 indicated she served as an on-call nurse and had covered call on the weekend. She indicated she did not know how residents obtained funds on weekends and she had not been trained in this matter. She indicated she would call the Director of Nursing or Administrator</p>			

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	<p>for assistance.</p> <p>During a 4/28/16, 9:10 a.m. interview, the Administrator indicated resident funds were stored in the medication cart on the assisted living area of the building during the weekends. He was unable to provide documentation indicating nursing personal and residents had been informed of the method to obtain access to resident's personal funds on weekends.</p> <p>Review of a 4/27/16, "Current Balance Report" indicated the facility managed resident's personal funds accounts for 5 residents who resided in the health care area of the facility. Residents #33 and #1 were included on the list.</p> <p>Page 26 of the "Resident Move-in Guide", which was provided by the Administrator on 4/28/16 at 9:59 a.m., indicated, "The facility will provide to you and/or your representative (sponsor) access to your funds upon your request." The guide did not offer directions as to how funds were to be maintained on weekends.</p> <p>3.1-6(b)</p>			
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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide psychiatric services for 1 of 4 residents reviewed for fall prevention (Resident #34).</p> <p>Findings include:</p> <p>The record of Resident #34 was reviewed on 4/27/16 at 1:54 p.m. Resident #34 had current diagnoses which included, but were not limited to, Parkinson's disease, muscle weakness, mental disorder, hypertension, and major depressive disorder.</p> <p>Resident #34 had a current, 2/15/16, physician's orders which included, but were not limited to, Bupropion 75 mg (anti-depressant), Mirtazapine 7.5 mg (anti-depressant), Prozac 40 mg (anti-depressant), psychiatric service provider to evaluate and treat.</p> <p>Resident #34 had a 4/10/16, quarterly, Minimum Data Set (MDS) assessment which indicated functional ability of</p>	F 0250	<p>F 250 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #34 Facility will provide psychiatric services. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will ensure facility provides physician ordered psychiatric services. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the license nurses on the following guideline: When to notify social services. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Facility has provided Physician ordered psychiatric</p>	05/23/2016

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	<p>extensive assistance with bed mobility, transfers, walking in and out of the room, locomotion on and off the unit, dressing, toileting, and personal hygiene. It also indicated the resident was cognitively intact, and made decisions consistent/reasonable.</p> <p>Resident #34 had a current, 4/14/16, care plan problem/need regarding "I am at risk for adverse consequences related to receiving antidepressant medication for treatment of depression." This care plan problem/need originated on 10/14/15. The goal for this problem/need was "I will not exhibit signs of drug related side effects or adverse drug reaction." Approaches to this problem/need included, but were not limited to, "administer my medication as physician ordered, observe my mood and response to medication".</p> <p>Resident #34 had a 2/14/16, "Fall Circumstance report", which indicated the resident had reported a fall to the staff. The resident refused to use alarms and family requested the resident be evaluated by psychiatric services for non-compliance and safety awareness issues.</p> <p>Resident #34 had a 2/14/16, at 12:59</p>		<p>services. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>p.m., "progress note", which indicated nursing had noticed a cognitive decline in the resident, in that he was unable to answer questions or respond at times.</p> <p>The resident's spouse reported to the son that Resident #34 was having difficulty feeding himself in the mornings. Resident #34's son was aware of the decline and in agreement to have psychiatric services evaluate the resident.</p> <p>During a 4/28/16, at 12:50 p.m., interview with Social Service #10, she indicated she had phoned the psychiatrists's nurse whom indicated Resident #34 had not been seen.</p> <p>During a 4/28/16, at 1:50 p.m., interview with Social Service #10, she indicated she had become the Social Service Director in October, 2015. She indicated the protocol for the department head personnel was to review the computer notes from the day before or the weekend if it was Monday during our morning meeting. If there was an issue the floor staff felt needed to be addressed, the nurse would initiate an "event" in the clinical record. She also indicated during the clinical morning meeting physician orders were reviewed daily.</p> <p>A current (undated) facility policy titled, "GUIDELINES FOR WHEN TO</p>			

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F 0323 SS=G Bldg. 00	<p>NOTIFY SOCIAL SERVICES", provided by Medical Records Personnel #19 on 4/28/16 at 2:53 p.m., indicated: "To provide guidelines for staff on areas that should involve social services...The social service director/department should be notified for...resident/family concerns or potential concerns...change in personality or cognition...declining care or treatments".</p> <p>3.1-34 (a)</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 complete thorough root cause analysis after falls, implement interventions associated with the root cause of a fall,</p>	F 0323	F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #53 #34 and #1 facility completed the	05/23/2016

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	<p>update care plans to reflect current fall interventions and ensure interventions were communicated to direct care staff for 3 of 4 residents, who met the criteria for falls (Residents #53, #34 and #1). This deficient practice resulted in a hip fracture from repeated falls for Resident # 53.</p> <p>Findings include:</p> <p>1. Resident #53's clinical record was reviewed on 4/27/16 at 10:37 a.m. Resident #53's, 4/27/16, diagnoses included, but were not limited to, displaced fracture of right femur neck, right artificial hip joint and history of falls. Resident #53 was admitted to the facility on 3/9/16.</p> <p>Resident #53 had a, 3/16/16, admission, Minimum Date Set (MDS) assessment which indicated the resident had severe cognitive impairment and rarely or never made decisions, required assistance for transferring from surface to surface, required assistance to safely stand once seated, required assistance for all activities of daily living and had a history of falls prior to her admission to the long term care facility.</p> <p>Resident #53 had a 3/22/16, care plan problem/need which indicated she was at</p>		<p>following. 1. Root cause analysis after most recent fall. 2. Implemented interventions associated with the root cause of the fall. 3. Updated the careplan to reflect current fall interventions. 4. Ensured the interventions were communicated to the direct care staff.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with falls to ensure the most recent fall has the following completed. 1. Root cause analysis after most recent fall. 2. Implemented interventions associated with the root cause of the fall. 3. Updated the careplan to reflect current fall interventions. 4. Ensured the interventions were communicated to the direct care staff. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the license nurses on the following guideline: Falls management program guideline. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure</p>	

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	<p>risk for falls due to a fall history prior to admission.</p> <p>Resident #53 had a 3/25/16, 6:26 p.m., "Event Report" which indicated: "Res [resident] fell @ 6:20 pm in room. Res attempting to self dress for bed." She had fallen in her room. She was transferring herself. The fall was unwitnessed. The resident complained of pain due to a skin tear on her left arm. The resident had cognitive or memory impairment which effected safety or judgement.</p> <p>The 3/25/16, "Event Report" form additionally indicated the "New Interventions" added to reduce falls was to help the resident get ready for bed after dinner. The 3/28/16 "IDT [Inter Disciplinary Team] Review" note, also contained on this form, indicated the a new fall intervention would be to "educate resident to use call light to assist with dressing."</p> <p>Resident #53's fall prevention care plan interventions were updated 3/28/16 to "remind me to use call light to ask for assistance with dressing." The approach to assist the resident with changing her clothes after dinner was not added to the care plan.</p>		<p>compliance: 1. Root cause analysis after most recent fall. 2. Implemented interventions associated with the root cause of the fall. 3. Updated the careplan to reflect current fall interventions. 4. Ensured the interventions were communicated to the direct care staff. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>Resident #53 had a 4/1/16, 3:08 p.m., "Event Report" which indicated: "Resident lying on back with head resting on couch." She had fallen in her room. She was transferring herself. She had her walker. The fall was unwitnessed. She had complaints of pain in her right thigh. The resident had "horrible, intense pain." The resident had cognitive or memory impairment which effected safety or judgement.</p> <p>The 4/1/16, "Event Report" form additionally indicated the "New Interventions" added to reduce falls were "bed in lowest position" and "moved items to easy reach, describe-call light." The form did not indicate the resident was in bed or attempting to get in or out of bed at the time of her fall.</p> <p>The 4/1/16, "Event Report" form also indicated hip/femur/fibula/tibia x-rays were ordered as a result of this fall. The form did not indicate if the resident had been injured. The form did not contain an IDT note.</p> <p>Resident #53 had a 4/6/16, 2:15 p.m., "Resident Progress Note", which indicated the resident was readmitted to the hospital status post right [R] hemiarthroplasty [replacement of the</p>			

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	<p>femur head]...R hip incision [with] 15 staples intact."</p> <p>Resident #53 had a 4/13/16, 10:17 p.m., "Event Report" which indicated: "Resident found on floor in bathroom...CNA had took [sic] resident to the toilet and was told to pull call light when finished. Call was pulled by resident...found resident on the floor." She had fallen in her bathroom. She had attempted to transfer herself. She was in a new room following her recent hospitalization. The fall was not witnessed. The resident had cognitive or memory impairment which effected safety or judgement, the resident had difficulty understanding and following directions and the resident required assistance for transferring.</p> <p>The 4/13/16, "Event Report" form additionally indicated the "New Interventions" was "awaiting orders from MD [medial doctor]." The 4/18/16, "IDT [Inter Disciplinary Team] Review" note, also contained on this form, indicated "the facility will monitor." No interventions regarding toileting or bowel/bladder continence was added to the care plan. The facility did not assess the resident's ability to be left safely in the bathroom without a staff member present.</p>			

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	<p>The care plan intervention, added on 4/18/16, after the fall in the bathroom, was "I will wear proper, well maintained footwear with transfers and ambulation." The clinical record and "Event Report" lacked any indication that foot wear or lack there of was a contributing factor to the 4/18/16 fall or any other fall.</p> <p>During a 4/28/16, 12:39 p.m., interview with RN Consultant #20 and the Assistant Director of Nursing, they indicated an approach to remind a cognitively impaired and/ or memory impaired resident to ask for help or use the call light would most likely not be effective due to the resident's limitations. They indicated Resident #53's cognitive status should have been considered when adding fall prevention interventions. They also indicated if lowering the bed was an approach after a fall, the assessment should reflect that the resident was possibly trying to get in or out of bed at the time of the fall. They additionally indicated if foot wear was an added approach after a fall, the assessment should indicate footwear issues may have influenced the fall. The ADON and RN consultant indicated they could not determine why lowering the bed and proper footwear were added as fall prevention approaches following</p>			

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	<p>Resident #53's falls. Lastly they indicated that toileting needs and/or toileting assistance was not assessed after Resident #53's fall in the bathroom.</p> <p>During a 4/27/16, 10:51 a.m., observation, Resident #53 was being wheeled down the hallway by therapy staff. Resident #53 was seated calmly in her wheel chair and complied with all requests.</p> <p>During a 4/28/2016, 10:46 a.m., observation, Resident #53 was seated in her wheelchair in the lounge. She was calm and did not attempt to stand.</p> <p>2. The record of Resident #34 was reviewed on 4/27/16 at 1:54 p.m. Resident #34 had current diagnoses which included, but were not limited to, Parkinson's disease, muscle weakness, mental disorder, hypertension, and major depressive disorder.</p> <p>Resident #34 had a current, 3/14/16, physician's order for "bed and chair alarm to alert staff of unassisted transfers, check alarms every shift."</p> <p>Resident #34 had a, 4/10/16, quarterly, Minimum Data Set (MDS) assessment which indicated functional ability of extensive assist with bed mobility, transfers, ambulation, locomotion on and</p>			

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	<p>off the unit, dressing, toileting, and personal hygiene.</p> <p>Resident #34 had a current, 4/16/16 care plan problem/need regarding "I have a history of falling related to decreased balance." This care plan problem/need originated on 10/14/15. The goal for this problem/need was "I will remain free from injury." Approaches to this problem/need included, but were not limited to, "please add clip alarm to my chair and pressure alarm to bed to remind me to wait for assistance...."</p> <p>Resident #34 had a 4/16/16, "Fall Circumstance", which indicated "resident had a fall leaning forward trying to pick something up off the floor. Resident will have chair alarm replaced with clip alarm to alert staff if resident is leaning forward too far".</p> <p>During a 4/28/16, at 2:03 p.m., observation, Resident #34 was sitting on the side of her bed with her feet on the floor. CNA #15 pulled the wheel chair and placed it beside Resident #34's bed. CNA #15 applied a gait belt to the resident, assisted her to stand and pivot into the wheel chair. CNA #15 asked Resident #34 if she would like to remain</p>			

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	<p>in her wheel chair or be transferred into a cloth chair located in the room. Resident #34 indicated she would like to sit in the cloth chair. CNA #15 assisted Resident #34 into the cloth chair where a pad alarm was located on the seat of the cloth chair. She removed the gait belt and asked the resident if she needed anything else. Resident #34 indicated no. CNA #15 left the room. No clip alarm was attached to Resident #34 before CNA #15 left the room.</p> <p>During a 4/28/16, 2:14 p.m., interview, CNA #15 indicated she was unaware of a clip alarm intervention. CNA #15 indicated the interventions were located on the CNA's assignment sheet.</p> <p>During a 4/28/16, 2:24 p.m., interview, Medical Record Personnel #19 indicated she was responsible for updating interventions on the flowsheets for the CNA's.</p> <p>During a 4/29/16, 1:13 p.m., interview, CNA #16 and CNA #17 indicated they viewed the profile of the resident on the computer terminal to know what type of alarm interventions were needed. CNA #16 and CNA #17 looked at Resident #34's profile at the computer terminal.</p>			

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	<p>Resident #34's profile indicated a clip alarm to the chair.</p> <p>During a 4/29/16, 1:13 p.m., observation, CNA #17 went to Resident #34's room. No clip alarm was observed attached to the resident. Resident #34 indicated no one had utilized a clip alarm and she had not been informed of a clip alarm intervention.</p> <p>During a 4/29/16, 1:25 p.m., interview, LPN #18 indicated the clip alarm should have been utilized continuously for Resident #34.</p> <p>During a 4/29/16, 1:35 p.m., observation, CNA # 17 applied a clip alarm to Resident #34.</p> <p>A current 4/25/16, facility flowsheet titled, "Assignment Sheet", provided by CNA #15 on 4/28/16 at 2:14 p.m., indicated Resident #34's devices were bed and chair alarms. No clip alarm was indicated.</p> <p>3. A review of the medical record for Resident #1 was completed on 4/25/2016 at 10:46 a.m. Her diagnoses included, but were not limited to diabetes mellitus, heart failure, anemia, chronic atrial fibrillation and edema. A, 3/18/16 quarterly Minimum Data Set assessment indicated Resident #1 was moderately cognitively impaired and was an</p>			

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	<p>extensive assist for mobility, transfer and locomotion.</p> <p>During a transfer of Resident #1 with CNA #1 and CNA #5 on 4/28/2016, 2:21 p.m., the following was observed: CNA #1 placed a gait belt around Resident #1 as she assisted her to sit on the edge of the bed. CNA #1 stood in front of Resident #1 and placed her right arm under the resident's right arm and CNA #5 placed her left arm under Resident #1's left arm. Together they transferred Resident #1 to her wheel chair. CNA #5 indicated she "always" used two people to transfer Resident #1. CNA #1 indicated that some days she can transfer Resident #1 by herself but it depended on how tired Resident #1 was and what kind of day she was having. Both CNA #1 and CNA #5 indicated they did not use any type of mechanical lift for Resident #1 for transfers.</p> <p>The "Event Report" for Resident #1, dated 3/17/2016, was provided by LPN #7 on 4/28/2016 at 8:06 a.m. It indicated Resident #1 fell out of the Sara Lift while transferring. The intervention listed was to "use the sling lift with all transfers."</p> <p>The CNA assignment sheet was provided by LPN #4 on 4/28/2016 at 3:01 p.m. It indicated Resident #1 was to be assisted</p>			

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	<p>by one staff member for transferring.</p> <p>The care plan for Resident #1 for the problem category listed "ADL's I have had a decline in my ability to perform ADL's due to weakness. I require extensive assist with my ADL's." Interventions included, but were not limited to, "Please use stand up lift to assist me when I need." This care plan was last updated on 2/22/2016. A current, 6/15, facility policy titled "Falls Management Program Guidelines", provided by Medical Records Personnel #19 on 4/28/16 at 4:30 p.m., indicated: "Should the resident experience a fall the attending nurse shall complete the 'Fall Circumstance and Reassessment Form.' The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episodes and a review by IDT to evaluate thoroughness of the investigation and appropriate interventions...</p> <p>6. The resident Icare plan/profile should be updated to reflect new or change in interventions."</p> <p>3.1-45(a)(1)</p>						

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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure gradual dose reduction recommendations contained contraindication statements when the medication was not reduced for 1 of 5 residents reviewed for unnecessary medications (Resident #33)</p> <p>Findings include:</p>	F 0329	F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #33 facility will obtain a gradual dose recommendation from the MD that contains a contraindication statement related to medication not being reduced. Identification of other residents having the potential to be affected by the	05/23/2016

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	<p>On 4/27/16 at 10:54 a.m., Resident #33 was sitting in a chair in her room, watching television. She indicated she was "fine today."</p> <p>On 4/27/16 at 1:53 p.m., Resident #33 was walking with her walker, through the courtyard with activity staff.</p> <p>On 4/28/16 at 9:05 a.m., Resident #33 was sitting in a chair in her room, watching television.</p> <p>On 4/28/16 at 10:25 a.m., Resident #33 was walking down the hallway with her walker. She indicated she was "good."</p> <p>On 4/28/16 at 1:46 p.m., Resident #33 was in her bed on her right side with her eyes closed.</p> <p>The clinical record for Resident #33 was reviewed on 4/26/16 at 3:52 p.m. Diagnoses for Resident #33 included, but were not limited to, insomnia, depression, and anxiety.</p> <p>Current physician orders for Resident #33 included, but were not limited to, the following:</p> <p>a. Trazodone (an anti-depressant medication also used for sleep aid) 50 mg via gastric tube every day at bedtime.</p>		<p>same alleged deficient practice and corrective actions taken: DHS or designee will review the most recent pharmacy gradual dose reduction recommendations to ensure a contraindication statement is documented by MD when a medication is not reduced. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the license nurses on the following guideline: Psychotropic medication usage and gradual dose reductions. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review the most recent pharmacy gradual dose reduction recommendations to ensure a contraindication statement is documented by MD when a medication is not reduced. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>The original date of this order was 10/1/15.</p> <p>b. Brintellix (an anti-depressant medication) 10 mg via gastric tube once a day. The original date of this order was 3/25/15.</p> <p>c. Xanax (an anti-anxiety medication) 0.25 mg via gastric tube twice a day, hold for daytime sedation. The original date of this order was 10/1/15.</p> <p>d. Xanax 0.5 mg as needed every eight hours for anxiety. The original date of this order was 2/1/16.</p> <p>Resident #33 had a health care plan, dated 11/24/15, which indicated she was receiving psychotropic medication for depression, anxiety, and insomnia. One of the approaches for this problem was for the physician to monitor the medications to "ensure I am receiving the lowest therapeutic dose."</p> <p>A social services progress note, dated 1/19/16 indicated an annual Minimum Data Assessment (MDS) had been completed. The MDS indicated Resident #33 was cognitively intact and her decisions were consistent and reasonable. The note indicated the resident "feels tired often, but will just lie down and take</p>			

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	<p>a nap." The note further indicated the resident "has no concerns at this time."</p> <p>A social services progress note, dated 4/20/16, indicated a quarterly MDS had been completed. The note indicated Resident #33 stated "no concerns at this time."</p> <p>A Nurse Practitioner note for Resident #33, dated 12/22/15, did not have insomnia listed as a problem. The note indicated "sleep patterns: patient has no changes to sleep patterns."</p> <p>A Physician note for Resident #33, dated 2/19/16, did not have insomnia listed as a problem. The note indicated "sleep patterns: patient has no changes to sleep patterns."</p> <p>A Nurse Practitioner note for Resident #33, dated 4/20/16, did not have insomnia listed as a problem. The note indicated "sleep patterns: patient has no changes to sleep patterns." The note further indicated "psychiatric: alert and oriented, no unusual anxiety or evidence of depression."</p> <p>A nurse monthly assessment, dated 4/22/16, indicated Resident #33 responded "no" to the question "do you have trouble sleeping at night?" The</p>			

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	<p>resident indicated she slept 8 hours when asked "how much do you sleep at night?" The resident also indicated she did take naps during the afternoon.</p> <p>A nurse monthly assessment, dated 3/18/16, indicated Resident #33 responded "no" to the question "do you have trouble sleeping at night?"</p> <p>A nurse monthly assessment, dated 2/19/16, indicated Resident #33 responded "no" to the question "do you have trouble sleeping at night?"</p> <p>A nurse monthly assessment, dated 1/17/16, indicated Resident #33 responded "no" to the question "do you have trouble sleeping at night?" The resident indicated she slept 8 hours when asked "how much do you sleep at night?" The resident also indicated she did take naps during the afternoon.</p> <p>A nurse monthly assessment, dated 12/28/15, indicated Resident #33 responded "no" to the question "do you have trouble sleeping at night?" The resident indicated she slept 8 hours when asked "how much do you sleep at night?" The resident also indicated she did not take naps during the day.</p> <p>Review of the nurses notes from 11/2/15</p>			

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	<p>to 4/29/16, lacked any documentation related to Resident #33 not sleeping well.</p> <p>A pharmacy recommendation for Resident #33, dated 12/3/15, indicated Trazodone 50 mg was due for a quarterly dosage reduction evaluation. The recommendation stated "Please evaluate s/sx [signs and symptoms] of insomnia and determine if reduction may be appropriate at this time." The physician had checked marked the disagree box. The recommendation was signed by the physician and dated 12/29/15. No contraindication and/or risk benefit analysis was on the pharmacy recommendation.</p> <p>A pharmacy recommendation for Resident #33, dated 3/7/16, indicated Trazodone was due for a dosage reduction evaluation. The recommendation stated "If sleeping ok, may consider trial reduction in TRAZODONE 25 MG QD [every day] at this time." There was no response from the physician on the pharmacy recommendation.</p> <p>A psychiatry progress note, dated 4/22/16, indicated Resident #33 was seen to due to insurance changes which would impact her medications. The note indicated "sleep: usually well." The note</p>			

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	<p>indicated to continue Trazodone 50 mg at bedtime. No contraindication statement and/or risk benefit analysis was provided by the physician.</p> <p>During an interview on 4/27/16 at 10:20 a.m., the Social Services Director indicated behaviors were documented under events, progress notes (nurses notes), or clinical at risk notes.</p> <p>During an interview on 4/29/16 at 8:56 a.m., additional information related to the gradual dose reductions for Resident #33 was requested of the Assistant Director of Nursing, Medical Records Personnel #19, and RN Consultant #20,</p> <p>During an interview on 4/29/16 at 12:54 p.m., Resident #33 indicated she sleeps very well. She further indicated she sometimes will even take a nap in the afternoon.</p> <p>Review of the current, August 2013, facility policy, titled "Psychotropic Medication Usage and Gradual Dose Reductions", provided by the Medical Records Personal #19 on 4/29/16 at 2:22 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure every effort is made for residents receiving psychoactive</p>			

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F 0371 SS=F Bldg. 00	<p>medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...</p> <p>...4. A gradual dose reduction [GDR] will be attempted for two [2] separate quarters [with at least one month between attempts] per the physician's recommendation. Gradual dose reduction must be attempted annually thereafter, unless medically contraindicated.</p> <p>5. Sedative/hypnotics will be reviewed quarterly for gradual dose reduction per the physician's recommendation. GDR shall be attempted quarterly unless clinically contraindicated...."</p> <p>3.1-48(b)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to distribute food under sanitary conditions regarding cleanliness. This deficient</p>	F 0371	F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following areas	05/23/2016

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	<p>practice had the potential to impact the 49 of 49 residents who ate food prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During a 4/25/16, 7:07 a.m., kitchen sanitation tour the following were observed:</p> <p>a. The floor tiles around the outer edge of the entire kitchen had build up of black discolored residue.</p> <p>b. The dry storage area had broken plastic pieces, and torn brown paper on the floor under the shelving.</p> <p>c. The knobs and casters of the stove and ovens were covered with a thick black, brown, sticky residue.</p> <p>d. The front cover of the ice machine was covered with a white and rust color residue.</p> <p>e. The dish machine racks were stored on the clean side of the dish machine. The same shelf had a brown water hose with black, brown, and white residue on it. The racks and hose were stored side by side.</p> <p>f. The ceiling area beside the oven and</p>		<p>were cleaned: 1 The floor tile around the outer edge of the kitchen. 2 The dry storage area floor and under the shelving. 3 The knobs and casters of the stove and ovens. 4 The front cover of the ice machine. 5 The dish machine brown water hose. 6 The ceiling area beside the oven and the condiment refrigerator. 7 The threshold between the dietary manager office and the kitchen area.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary manager or designee will re-educate the dietary team on the following guideline: 1 Cleaning schedule Dietary manager updated the cleaning schedule to include the following: 1 Clean the outside of ice machine. 2 Check the ceiling for splatters. 3 Monthly deep clean to include all base boards all equipment knobs and wheels as needed. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of the kitchen will be conducted by dietary manager or</p>		

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	<p>the condiment refrigerator had a red substance splattered on it. The Dietary Manager indicated it was ketchup.</p> <p>g. The threshold between the Dietary Manager's office and the kitchen area had a build up of black residue.</p> <p>During a 4/28/16, at 1:07 p.m., interview the Dietary Manager, she indicated the cleaning scheduled lacked the following:</p> <p>a. Clean the outside of the ice machine.</p> <p>b. Check ceiling for splatters.</p> <p>c. Monthly Deep Clean: all baseboards, all equipment, knobs and wheels as needed.</p> <p>During an interview on 4/29/16 at 3:15 p.m., the Dietary Manager indicated 49 health care residents were served meals from the facility kitchen.</p> <p>A current, 1/2013, facility policy titled "Job Duty Schedules", which was provided by the Dietary Manager on 4/28/16 at 1:07 p.m., indicated the following: "A detailed list of job responsibilities and approximate time frames for completion will be provided for each position and shift if applicable...The schedule is</p>		<p>designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Updated cleaning schedule for completeness. 2. Inspect 5 pieces of equipment and 5 areas of the kitchen to ensure they are clean. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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F 0431 SS=E Bldg. 00	<p>concise list of what specific responsibilities are to be completed, at specific times as applicable, during the employees's shift."</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only 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</p>			

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	<p>Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were stored properly and in a sanitary manner for two of three medication carts. The facility failed to ensure over the counter medications were labeled with resident identification for two of three treatments carts. The facility failed to ensure expired medications were disposed of properly for one of three medication rooms.</p> <p>Findings include:</p> <p>During a tour of medication storage of the 100 Hall, 200 Hall and 300 Hall with Unit Manager #6 on 4/29/2016 at 8:26 a.m., the following were observed:</p> <p>1. In the 100 Hall medication cart second drawer, there were four and one half white pills and one red pill loose at the bottom of the drawer. Two and one half white pills and two pink pills were loose at the bottom of the third drawer. Unit Manager #6 indicated the pills should not be out of their packaging in the bottom of the drawers.</p>	F 0431	<p>F 431 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following was completed: 1. 100 hall medication cart - removed of and properly destroyed any loose pills. 2. 200 hall medication storage room - the vial of Meijer brand lubricated eye drops were destroyed. 3. 200 hall medication cart - the syringe of Enoxaparin Solution was destroyed. Removed of and properly destroyed any loose pills. 4. 300 hall medication storage room - the 4 oz tube of skin integrity hydrogel was destroyed. The expired heparin flush syringe was destroyed.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All med carts were audited to ensure the following: 1. medications were stored properly and a sanitary manner. 2. Over the counter medications are labeled with resident identification. 3. Expired medications are disposed of properly. Measures put in place and systemic changes made to</p>	05/23/2016

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NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304			
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	<p>2. In the 200 Hall Medication storage room, a vial of Meijer brand lubricated eye drops were sitting on the top of the treatment cart. There was no label indicating what resident they were to be used for. Unit Manager #6 indicated she did not know who the eye drops belonged to.</p> <p>3. In the top drawer of the medication cart on the 200 Hall, there was a syringe of Enoxaparin Solution (anti-coagulant) 30 mg/ 0.3. The package did not have a resident name on it. Unit manager #6 indicated she did not know which resident the anti-coagulant was being used for and indicated it should be discarded. In the second drawer of the medication cart, there were one orange pill and one pink pill laying in the bottom of the drawer.</p> <p>4. In the 300 hall medication storage room, a 4 oz tube of Skintegrity Hydrogel (wound cream) was in the top drawer of the treatment cart. There was no resident name or label on the tube. Unit Manager #6 indicated there were no residents in the facility who were using Skintegrity (skin treatment) currently and the medication should have been discarded. There was a Heparin flush syringe in the cabinet with an expiration date of 2/2016.</p>		<p>ensure the alleged deficient practice does not recur: DHS or designee will re-educate the license nurses on the following guideline: Medication Storage in the Facility How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for all medication carts will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. medications were stored properly and in a sanitary manner. 2. Over the counter medications are labeled with resident identification. 3. Expired medications are disposed of properly. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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F 0441	<p>There was no resident identifier on the syringe. Unit manager #6 indicated no one was using heparin flushes currently and the medication should have been discarded.</p> <p>The policy titled "MEDICATION STORAGE IN THE FACILITY" dated 9/1/13, provided by LPN #7 on 4/29/2016 at 10:07 a.m., indicated: "Policy Medications medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier....A. The provider pharmacy dispenses medications in containers that meet legal requirements...Medications are kept in the containers...L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...."</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(o)</p>			

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SS=D Bldg. 00	<p>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to post</p>	F 0441	F 441 Corrective actions accomplished for those residents found to be affected	05/23/2016	

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	<p>signage, provide Personal Protective Equipment for employees, failed to prevent cross contamination during wound care and failed to wear gloves while touching an isolation resident's belongings (Resident #1).</p> <p>Findings include:</p> <p>1. a. A review of the medical record for Resident #1 was completed on 4/25/2016 at 10:46 a.m. Her diagnoses included, but were not limited to, diabetes mellitus, heart failure, anemia, chronic atrial fibrillation and edema. The quarterly, 3/18/16, Minimum Data Set assessment indicated Resident #1 was moderately cognitively impaired and frequently incontinent of bowel. The assessment for urinary continence was not completed because the resident had a urinary catheter.</p> <p>A care plan for Resident #1 was dated 4/28/2016 and indicated the problem category of "Bowel and Bladder I have a urinary tract infection with MRSA and am in contact isolation." Interventions included but were not limited to "Keep my perineal area clean and dry."</p> <p>During an observation on 4/25/2016 at 10:02 a.m., Resident #1's room did not</p>		<p>by the alleged deficient practice: Resident #1 contact isolation has been discontinued per physician order.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will observe all resident in isolation to ensure the following: 1. Signage is posted. 2. Personal protective equipment is provided for employees. 3. If applicable wound care completed without cross contamination. 4. Gloves are worn when touching residents belongings. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following guideline: Contact precautions How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for all residents in isolation will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Signage is posted. 2. Personal protective equipment is provided for employees. 3. If applicable wound care completed without cross contamination. 4. Gloves are worn when touching residents</p>				

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	<p>have an isolation precaution sign on the door.</p> <p>During an observation on 4/25/2016 at 12:35 p.m., Resident #1's room did not have an isolation precaution sign on the door.</p> <p>During an observation on 4/26/2016 at 9:08 a.m., Resident #1's room did not have an isolation precaution sign on the door.</p> <p>During an observation on 4/26/2016 at 1:44 p.m., Resident #1's room did not have an isolation precaution sign on the door.</p> <p>During an observation on 4/26/2016 at 2:25 p.m. , Resident #1's room did not have an isolation precaution sign on the door.</p> <p>On 4/28/2016 at 7:41 a.m., there was a white plastic three drawer container containing isolation gowns and gloves outside the door for Resident #1. There was no sign indicating isolation precautions should be taken for either resident residing in that room.</p> <p>1. b. During a 4/8/16, 1:25 p.m., pressure ulcer treatment with LPN #4 and Unit Manager #3 the following was observed:</p>		<p>belongings. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>LPN #4 gathered several packets of ointment and washed her hands in the bathroom at the nurses station. LPN #4 then entered Resident #1's room without wearing a gown or gloves. She asked the visitor to wait in the hallway so a treatment could be completed. The roommate was not in the room at this time.</p> <p>The visitor, who had been visiting Resident #1's bedside, was not wearing a gown or gloves while at Resident #1's bedside. As LPN #4 was putting on the yellow isolation gown and gloves, the visitor asked her if the yellow gowns meant that Resident #1 was contagious, LPN #4 replied that Resident #1 was not contagious and entered the room.</p> <p>LPN #4 and Unit Manager #3 grabbed the draw sheet from under the resident and pulled her up in bed. LPN #4 then removed the resident's blankets with her gloved right hand. She opened the packet of Calmoseptine (moisture barrier) ointment, squeezed it onto her right gloved hand and applied the cream to the resident's left inner thigh. Using her right hand she then pulled the resident brief down, and continued to apply cream back and forth to both the right and left inner thighs. LPN #4 then asked the resident if it was okay to leave the brief</p>			

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	<p>down away from her body so the pressure ulcer could be "open to air". Using her soiled gloved hands, LPN #4 then pulled the blankets up to cover Resident #1. LPN #4 then removed her soiled gloves, reached down and used the bed control of Resident #1 to sit her up in bed. LPN #4 had not washer her hands prior to using the bed control.</p> <p>All PPE [personal protective equipment] was removed and placed into a clear plastic trash bag. LPN #4 washed her hands then removed the bag containing soiled isolation garments from the trash can and tied it with ungloved hands and carried it down the hallway. She gave the bag to an ungloved CNA (Certified Nursing Assistant) to place in the soiled utility room.</p> <p>1. c. On 4/29/2016 at 7:32 a.m., there was a white plastic three drawer container containing isolation gowns and gloves outside the door for Resident #1 and her roommate. There was no sign indicating isolation precautions should be taken for either resident residing in the room.</p> <p>During an interview with Unit Manager #3 on 4/26/2016 at 9:33 a.m., she indicated Resident #1's catheter had been discontinued.</p>			

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	<p>During an interview with CNA #1 on 4/28/2016 at 2:21 p.m., she indicated Resident #1 had been incontinent earlier that day.</p> <p>During an interview with LPN #4 on 4/29/2016 at 9:34 a.m., she indicated Resident #1 had been placed in contact isolation either Tuesday (4/26/16) or Wednesday (4/27/16) of that week. She then indicated that it was the responsibility of the nurse receiving the order to place the isolation sign, put drawers outside of the room and inform the staff. LPN #4 also indicated she did not realize she had taken her gloves off and touched bed items during the 4/28/16 pressure area treatment. She indicated only staff providing personal care would need to use the isolation precautions.</p> <p>During on interview with the ADHS (Assistant Director of Health Services) on 4/29/2016 at 9:39 a.m., she indicated Resident #1 had a history of MRSA (Methicillin-resistant Staphylococcus aureus) in her urine since at least January but did not know how long that she had been MRSA positive. She indicated that Resident #1 was in isolation for MRSA in the past and was not sure why it was removed. She indicated Resident #1 should have had isolation precautions</p>			

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	<p>prior to today. ADHS indicated that even though Resident #1 had a catheter a CNA or Nurse could have been been exposed to the urine while emptying the catheter bag. ADHS indicated Resident #1 did not have any negative cultures that she knew of. She indicated she was waiting for the final result of urinary analysis that had been sent in on Monday (4/25/16) to put Resident #1 back into contact isolation.</p> <p>The CNA assignment sheet for the 200 Hall was provided by LPN #4 on 3/28/2016 at 3:01 p.m., and indicated Resident #1 was both continent and incontinent of urine.</p> <p>The "General Order" for Resident #1 was provided by Unit Manager #6 on 4/29/2016 at 12:53 p.m., indicated an order for a Foley catheter (urinary catheter) to begin on 1/30/2016. The report indicated the Foley catheter was discontinued on 4/25/2016.</p> <p>The urine culture result for Resident #1 provided by Unit Manager #6 on 4/29/2016 at 12:53 p.m., indicated the urine specimen collected on 3/26/2016 indicated her urine was positive for MRSA (Methicillin-resistant Staphylococcus aureus). The lab results were received on 3/30/2016 at 12:07 p.m. Unit Manager #6 indicated there were no</p>			

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	<p>other UA results documented.</p> <p>The policy titled "Guidelines for Contact Precautions", dated January 2015, was provided by the Nurse Consultant #8 on 4/28/2016 at 2:30 p.m. It indicated "Purpose: To provide guidelines to prevent the spread of infectious disease organisms...Procedures: 1. ...B. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the resident's environment. 2. Contact precautions are indicated to prevent and control HAI (health-care associated infections) transmission of infection with any of the following...Staphylococcus aureus resistant to Methicillin/oxacillin (MRSA) if present in a site that has copious secretions not contained...4. b...If residents cohabituate without similar organisms, contact precautions are implemented for individual resident...5. Personal Protective Equipment: a. Wear gloves before contact with the resident or environmental objects. b. Wear clean non sterile, fluid resistant gown when entering the room if it is anticipated clothing will have substantial contact with the resident or environmental surface or when there is a likelihood that organisms from ...urine...may be on surfaces or items in the resident's rooms...6. Precaution Sign: a. Post a sign at the resident's door to advise the</p>			

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F 0514 SS=D Bldg. 00	<p>visitors to report to nurses station before entering the room...9. Visitors: a. Visitors must be taught how to properly gown and glove by facility staff...11. Environmental Control: ...c. Gloves should be worn to empty trash, to gather soiled linen and to remove trash and linen bags from resident rooms...12. Notification/Documentation of Positive Cultures: a. Upon verification that a resident has an infection that requires Contact Precautions, the nurse will implement the precautions and inform the attending physician, appropriate department heads, nursing staff, the infection control practitioner, the resident and the resident's family. b. Document the notification. c. Update the Care Plan."</p> <p>No further documentation was provided by the facility prior to time of exit. 3.1-18(j)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>			

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	<p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure resident records were completely and accurately documented regarding sliding scale insulin administration for 2 of 2 residents reviewed for documentation of sliding scale insulin (Residents #21 and #1).</p> <p>Findings include:</p> <p>1. Resident #21's clinical record was reviewed on 4/28/16 at 1:00 p.m. Resident #21's diagnoses included, but were not limited to, Type 2 diabetes mellitus and hypertension.</p> <p>Resident #21 had a current 3/28/16, physician's order for Novolog Flexpen (Insulin) per sliding scale as follows: If blood sugar was 200 to 250, give 2 units, If blood sugar was 251 to 300, give 4 units, If blood sugar was 301 to 350, give 6 units, If blood sugar was 351 to 400, give 8 units, If blood sugar was 401 to 450, give 10 units,</p>	F 0514	<p>F 514 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #21 has been discharged. Resident #1 sliding scale insulin order updated to include accurate documentation of units administered.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with sliding scale insulin order updated to include accurate documentation of units administered. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1. Specific Medication Administration Procedures 2. Medical Records Management How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for all residents receiving sliding scale insulin will be conducted by the</p>	05/23/2016

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	<p>If blood sugar was 451 to 500 give 12 units, If blood sugar was over 500, call the Medical Doctor. Subcutaneous before meals and at bedtime.</p> <p>Resident #21's medication administration record for 3/29/16 to 4/27/16 at 12:58 p.m., was reviewed. Resident #21 had 4 times when his blood sugar range would have required sliding scale insulin coverage during this 30 day period. Although the blood sugar level was documented before meals and after bedtime, the amount of insulin administered and the administration site was not recorded for any of the 4 times (3/31/16- 3:30 p.m. to 6:30 p.m. check-205 mg , 3/31/16- 7:00 p.m. to 11:00 p.m. check-229 mg, 4/1/16- 10:00 a.m. to 12:30 p.m. check - 212 mg, and 4/1/16- 7:00 p.m. to 11:00 p.m. check -213 mg).</p> <p>During a 4/27/16, 1:39 p.m., interview, Medical Records Personnel #19 indicated there was an error when putting the sliding scale orders into the electronic medical records. The error resulted in no space provided to document the sliding scale insulin amount and the site location. This error had not occurred for every resident who was receiving sliding scale</p>		<p>DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Sliding scale insulin order includes requirement for units administered to be documented The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>insulin. Residents #1 and #21 had been impacted by this error. Medical Records Personnel #19 indicated nursing personal had indicated they had administered sliding scale insulin when indicated but had not realized the electronic record was not recording the amount given. 2. A review of the medical record for Resident #1 was completed on 4/25/2016 at 10:46 a.m. Her diagnoses included but were not limited to diabetes mellitus, heart failure, anemia, chronic atrial fibrillation and edema. A 3/18/16, quarterly Minimum Data Set indicated Resident #1 was moderately cognitively impaired.</p> <p>During an interview with LPN #7 on 4/27/2016 at 1:38 p.m., she indicated nursing was not documenting the amount of insulin given to some residents who were on a sliding scale including Resident #1. LPN #7 indicated some residents at the facility had the amount of insulin documented but not everyone.</p> <p>A physician order for Resident #1 was "Humalog KwikPen (Insulin lispro) insulin pen; 100 units/mL: amt per sliding scale; if Blood Sugar is less than 60 call MD [Medical Doctor] if Blood Sugar is 200-250 give 2 units if Blood Sugar is 251-300 give 4 units if Blood Sugar is 301-350 give 6 units</p>			

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	<p>if Blood Sugar is 351-400 give 8 units if Blood Sugar is 401-450 give 10 units if Blood Sugar is 451-500 give 12 units if Blood Sugar is greater than 500, call MD [Medical Doctor] subcutaneous"</p> <p>The Medication Administration Record (MAR) for Resident #1 for 3/28/2016 through 4/27/2016 was provided by LPN #7 on 4/27/2016 at 1:35 p.m., The MAR indicated the Humalog had been administered and where the injection was placed. There was no indication of how much insulin had been given. A current, 9/25/14, facility policy titled "Guidelines For Medical Records Management", which was provided by Medial Records Personal #19 on 4/29/16 at 10:37 a.m. It indicated: " Purpose: To maintain medical records in accordance with established guidelines. Procedure: The medical record shall contain sufficient information to identify and assess the resident/patient and furnish evidence on the course of the resident/patient's health/medical care."</p> <p>A current, 9/1/13, facility policy titled "Specific Medication Administration Procedures", which was provided by Medical Records Personal #19 on 4/28/16 at 2:54 p.m., indicated:</p>			

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R 0000 Bldg. 00	<p>"After administration, return to cart, replace medication container (if multi-dose and doses remain), and document in the MAR [Medication Administration Record or TAR [Treatment Administration Record]."</p> <p>3.1-50(a)(1)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 36</p> <p>Sample:7</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on May 6, 2016.</p>	R 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on April 29, 2016. Please accept this plan of correction as the provider's credible allegation of</p>	

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R 0273 Bldg. 00	<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> <p>Based on observation, interview and record review, the facility failed to distribute food under sanitary conditions regarding cleanliness. Of the facility's 36 residents, this deficient practice had the potential to impact the 36 residents who ate food prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During a 4/25/16, 7:07 a.m., kitchen sanitation tour the following concerns were observed:</p> <p>a. The floor tiles around the outer edge of the entire kitchen had build up of black discolored residue.</p> <p>b. The dry storage area had broken plastic pieces, and torn brown paper on the floor under the shelving.</p> <p>c. The knobs and casters of the stove and ovens were covered with a thick black, brown, sticky residue.</p>	R 0273	<p>compliance.</p> <p>R 273 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following areas were cleaned: 1 The floor tile around the outer edge of the kitchen. 2 The dry storage area floor and under the shelving. 3 The knobs and casters of the stove and ovens. 4 The front cover of the ice machine. 5 The dish machine brown water hose. 6 The ceiling area beside the oven and the condiment refrigerator. 7 The threshold between the dietary manager office and the kitchen area.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary manager or designee will re-educate the dietary team on the following guideline: 1</p>	05/23/2016

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	<p>d. The front cover of the ice machine was covered with a white and rust color residue.</p> <p>e. The dish machine racks were stored on the clean side of the dish machine. The same shelf had a brown water hose with black, brown, and white residue on it. The racks and hose were stored side by side.</p> <p>f. The ceiling area beside the oven and the condiment refrigerator had a red substance splattered on it. The Dietary Manager indicated it was ketchup.</p> <p>g. The threshold between the Dietary Managers office and the kitchen area had a build up of black residue.</p> <p>During a 4/28/16, at 1:07 p.m., interview the Dietary Manager indicated the cleaning scheduled lacked the following:</p> <p>a. Clean the outside of the ice machine.</p> <p>b. Check ceiling for splatters.</p> <p>c. Monthly Deep Clean: all baseboards, all equipment, knobs and wheels as needed.</p> <p>During an interview on 4/29/16 at 3:15 p.m., the Dietary Manager indicated 33</p>		<p>Cleaning schedule Dieatary manager updated the cleaning schedule to include the following: 1 Clean the outside of ice machine. 2 Check the ceiling for splatters. 3 Monthly deep clean to include all base boards all equipment knobs and wheels as needed. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of the kitchen will be conducted by dietary manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Updated cleaning schedule for completeness. 2. Inspect 5 pieces of equipment and 5 areas of the kitchen to ensure they are clean. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>residential residents were served meals from the facility kitchen.</p> <p>A current, 1/2013, facility policy titled "Job Duty Schedules", which was provided by the Dietary Manager on 4/28/16 at 1:07 p.m., indicated the following: "A detailed list of job responsibilities and approximate time frames for completion will be provided for each position and shift if applicable... The schedule is concise list of what specific responsibilities are to be completed, at specific times as applicable, during the employees's shift."</p>			