STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155220		06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00171835. This visit was in conjunction with the Investigation of Complaint IN00174299. Complaint IN00171835 - Substantiated. Federal/State deficiency related to the allegations is cited at F-494. Survey dates: May 26, 27, 28, 29, June 1, 2, and 3, 2015. Facility number: 000125 Provider number: 155220 Aim number: 100266740 Census bed type: SNF/NF: 129 Residential: 46 Total: 175 Census payor type: Medicare: 30 Medicaid: 75 Other: 24 Total: 129 These deficiencies reflect State findings	F 0000	Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2-3.1.			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded related to the	F 0278	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by	06/17/2015

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	resident's dental status and assessment for 1 of 3 residents reviewed for dental status of the 6 residents who met the criteria for dental status. (Resident #113) Finding includes: On 5/27/2015 at 9:36 a.m., Resident #113 was observed in her room. At that time, she was observed to have broken and carried front teeth (decayed teeth). The record for Resident #113 was reviewed on 5/28/15 at 12:51 p.m. The resident's diagnosis included, but were not limited to, Alzheimer's disease, muscle weakness, cellulite, nutritional deficiency, and cognitive deficits. The Significant Change MDS assessment dated 3/26/15 was reviewed. The resident was not alert and oriented and required extensive assist for her activities of daily living. There were no dental concerns noted. Interview with MDS Coordinator #1 on 5/28/15 at 2:35 p.m., indicated the resident's dental status was coded incorrectly on the Significant Change assessment. She further indicated she had made a note the resident's teeth were broken and carried, however, she had coded the MDS incorrectly.		the facility and is submitted only in response to the regulatory requirement. **F278** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident **R113** is as follows: A modification was completed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. At minimum 20 residents most recent MDS assessment will be reviewed per week for accuracy until completion of resident roster. A modification will be completed for any inaccuracies. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: ·Performing observations of the resident's oral cavity to determine dental status ·Documenting the observation and coding the appropriate	

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	3.1-31(d)		answers on the MDS **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, the MDS team will audit 3 MDS's for each other to determine if it was coded accurately. A modification will be completed for any found with a miscoded entry. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,			

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	mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to ensure a care plan was developed related to personal hygiene including oral care and urinary incontinence for 1 of 3 residents reviewed for activities of daily living and for 1 of 3 residents reviewed for urinary incontinence. (Residents #17 &, #66) Findings include: 1. The record for Resident #66 was reviewed on 6/1/15 at 8:48 a.m. The resident's diagnoses included, but were not limited to, syncope, high blood pressure, fall, macular degeneration, debility, muscle weakness, and cognitive impairment. The Quarterly Minimum Data Set (MDS) assessment dated 3/31/15 indicated the resident was not alert and oriented. The resident had no behavior problems, rejection of care, or other mood problems. The resident was an extensive assist with one person physical assist for personal hygiene.	F 0279	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F279** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident **R66** is as follows: A care plan was completed for R66 related to personal hygiene and oral care. The corrective action for resident **R17** is as follows: A care plan was completed for R17 related to urinary incontinence. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents care plans were reviewed to ensure they included all necessary interventions related to their medical/clinical condition/pyschosocial. A care plan was generated for any	06/17/2015

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	Review of the current plan of care updated 3/2015 indicated there was no care plan addressing personal hygiene and oral care. Interview with MDS Coordinator #2 on 6/1/15 at 3:34 p.m. the Restorative Nurse completes the ADL (Activities of Daily Living) section of the MDS and she would be the person who would have created a care plan for the oral care. She indicated there should have been a care plan for personal hygiene and oral care. 2. Resident #17's record was reviewed on 5/28/15 at 9:09 a.m. Diagnoses included, but were not limited to, cardiomyopathy, urinary retention, benign prostatic hyperplasia, history of urinary tract infections, diabetes mellitus, muscle weakness, and hypertension. A 5 day admission MDS (Minimum Data Set) assessment dated 12/6/14 indicated Resident #17 was always continent of urine. A quarterly MDS assessment dated 3/6/15 indicated Resident #17 was frequently incontinent of urine. Review of all care plans for Resident #17 lacked documentation of any care plan to address his decline in urinary continence.		resident at that time who did not have one for the necessary area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · Reporting to the care plan team if a change is observed with the resident related to incontinence status and/or changes with their teeth, swallowing, chewing, or assistant with oral care. · Care plans will be created for any resident who needs assistance with personal hygiene and/or oral care as well as any resident who has incontinence. Inservice was held on June 23rd with nursing by Director of Nursing regarding the importance of following and implemented all care plans generated for the resident and what to do if the resident declines an intervention. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, the MDS team/designee will audit 3 residents care plans to ensure they are being implemented as written. Care plan team/physician will be notified of any refusals to make necessary changes if needed.	

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	An interview on 6/1/15 at 1:47 p.m., with the DON (Director of Nursing), indicated care plans were reviewed quarterly with the MDS assessments or with any significant change and should be updated at that time. An interview on 6/1/15 at 3:14 p.m., with MDS Coordinator #3, indicated the urinary incontinence section of the MDS assessments were done by the Restorative Nurse. The Restorative Nurse was interviewed on 6/1/15 at 3:16 p.m., regarding Resident #17's decline in urinary continence status from 12/6/14 to 3/6/15. The resident went from always continent to frequently incontinent. She indicated he did have more than 7 episodes of incontinence during the March time period. She further indicated, with that much of a change in status, a care plan would normally be put into place to address the issue and "it just got missed." 3.1-35(a)		A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	
F 0282 SS=D Bldg. 00	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			

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	persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow Physician's Orders and care plans related to the monitoring and assessment of skin for bruising for 2 of 3 residents reviewed for non-pressure related skin conditions of the 4 residents who met the criteria for non-pressure related skin conditions. The facility also failed to follow Physician's Orders related to completing daily weights as ordered for 1 of 3 residents reviewed for nutrition. (Resident #17, #24, and #95) 1. During an observation of Resident #24 on 5/27/15 at 8:45 a.m., a golf ball sized purplish discoloration was noted to the back of her right hand by her thumb. The resident indicated at the time of the observation, "I hit them all the time on the doorways when I'm pushing my wheelchair around." Resident #24 was observed on 6/1/2015 at 9:00 a.m., with the East Unit Manager (UM), who noted a purple discoloration/bruise to the resident's right hand. An interview at the time of the observation with the East UM indicated she did not remember any recent bruises to that area being monitored. She further indicated skin impairments including	F 0282	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F282** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident R95 is as follows: The physician was notified and weights were reviewed. There were no new orders The corrective action for resident R17 is as follows: A bruise event was completed for R17 and reported to the physician. The corrective action for resident R24 is as follows: A bruise event was completed for R24 and reported to the physician. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Daily weights were reviewed to determine if a current weight was maintained. Weights were obtained for any resident who was missing a daily weight. Skin	06/17/2015

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	bruising, were usually noted on shower days by the CNAs, but they were also instructed to visualize the resident' s skin with daily care and were to report any issues to their staff nurse who would then type an event note in the computer. The UM also indicated she printed out all events each morning from the previous day and reviewed them herself when an issue was resolved. An interview with CNA #3 on 6/2/15 at 10:50 a.m., indicated Resident #24 was a limited assist for ADL's (Activities of Daily Living) and staff helped her get her clothes out and stood by to assist if needed. An interview with the DON (Director of Nursing) on 6/2/15 at 11:07 a.m., indicated when CNAs had orientation and in-services, they were made aware to observe resident's skin during daily care and report any issues to the nurse. Resident #24's record was reviewed on 6/1/15 at 10:45 a.m. Diagnoses included, but were not limited to, anemia, Parkinson's, COPD (Chronic Obstructive Pulmonary Disease, a breathing disorder), and weakness. A review of the Progress Notes included assessments on 5/20/15, 5/21/15, 5/24/15		sweeps were completed to identify any new alterations in skin integrity. An event was completed for any new alterations and the physician notified. All care plans and physician orders were reviewed to ensure they are being implemented as ordered and/or specified **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · During ADL and/or showers observe for any alterations in skin integrity, such as bruises, rash, skin tears, wounds, scratches, etc. Report immediately to the nurse. The nurse must complete the appropriate event/observation as well as measure and describe the observation in Matrix. Notify the physician and appropriate family/legal representative. · Resident who are on daily/weekly weights must have their weights completed. If any resident refuses, immediately notify the nurse. Nurses – speak with the resident and explain rational for the weights and then document if the resident still refuses. C.N.A.'s – a re-weight should be taken if the daily or weekly weight is 3#'s different from the last weight. Notify nursing immediately if the re-weight is still 3#'s different from the last. Nurses – if a	

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	and 5/29/15 of healing specifically to bruises on the resident's left shin, left lower arm, right lateral upper arm, right forearm and right posterior arm. There was no documentation indicating bruising to the back of the resident's right hand near her thumb. Care plans were in place for a risk for impaired skin integrity r/t (related to) a history of bruises, scratches, and skin tears r/t fragile skin, anemia, decreased mobility and Parkinson's and for a risk for skin breakdown. Interventions included, but were not limited to, monitor bruises as ordered, report any deterioration in status of bruising to Physician and responsible party, and monitor skin during daily during routine care and notify charge nurse of any changes in skin. 2. During an observation of Resident #17 on 5/27/15 at 9:57 a.m., dark purplish, puffy discolorations were noted to both hands and forearms. At the time of the observation, the resident indicated he bumped them all the time on the doorjambs when moving his wheelchair around. He also indicated he bruised easily, had thin skin, and took a long time to heal due to his diabetes. Resident #17 was again observed on		resident is on daily weights, you must review the order to determine the parameters for physician notification related to the weight change. Document all attempts to notify the physician/responsible party of the change in weight and any new orders. On June 23rd nursing staff was inserviced related to importance of following all physicians orders and care plan interventions and what to do if resident is declines **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Three times a week, the Director of Nursing/designee will audit all residents on daily weights to determine if the weights were obtained. If there is no current weight, one will be obtained as soon as possible. Re-education will be provided to the staff on that unit about the importance of obtaining the weights daily. Weekly 6 residents will have skin observations completed. If skin alterations are observed the clinical record will be reviewed to determine if a skin event has been completed and the physician notified. If the event was not found, one will be completed immediately so monitoring can be started, and the physician notified. Weekly, 3 residents will have	

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	6/1/15 at 8:40 a.m., with the East Unit Manager (UM), who noted purple discolorations/bruises to the back of the resident's hands and a currently wrapped skin tear to his right wrist. An interview on 6/1/15 at 8:47 a.m., with the East UM indicated Resident #17 previously had bruises to the back of both hands which were completely gone and closed out by her. He did have an issue with constant bruising. She further indicated she did not see anything charted regarding bruises to his hands since 5/20/15 when those were closed out (healed), so the ones observed to his hands now were new. An interview on 6/2/15 at 10:46 a.m., with CNA #2, indicated Resident #17 was an extensive assist for ADLs including dressing. Staff helped him get started with his clothes and he did what he could from there. She further indicated if she ever noticed any skin areas during daily care for any resident, she passed it along to the nurse to assess. A follow up interview with the DON on 6/2/15 at 11:07 a.m., indicated when CNAs have orientation and in-services, they are made aware to observe resident's skin during daily care and report any issues to the nurse.		their care plans and orders reviewed to identify if they are being implemented as ordered/written. Care plan team and/or physician will be notified of any refusals to make necessary changes in needed. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	

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	Resident #17's record was reviewed on 5/28/15 at 9:09 a.m. Diagnoses included, but were not limited to, cardiomyopathy, peripheral vascular disease, diabetes mellitus, anemia, muscle weakness, and sleep apnea. Care plans were in place for impaired skin integrity related to skin tears and bruising, receives daily Coumadin and for a risk for skin breakdown. Interventions included, but were not limited to, monitor each bruise q (every) shift until resolved, and monitor skin during daily routine care and notify charge nurse if any changes in skin are noted. 3. Resident #95's record was reviewed on 5/28/15 at 9:41 a.m. Diagnoses included, but were not limited to, congestive heart failure, spondylosis, pressure ulcer heel, respiratory failure, urinary retention, edema, chronic pain,chronic kidney disease, diabetes mellitus, hypertension, cardiomegaly, and ischemic heart disease. Current Physician Orders included the following: - 4/6/15 Daily weights - notify MD if gain of 3# (pounds) or more in a day or 5# or more in a week			

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	Review of weights from the East Unit weight log from unit book and computer weight report were as follows: 4/7/15 = 209# 4/8/15 = 209 4/10/15 = 211 4/14/15 = 214.6 4/20/15 = 202.3 4/21/15 = 201.2 4/24/15 = 202.9 4/28/15 = 208.8 4/29/15 = 203.0 4/30/15 = 210.3 5/1/15 = 206.3 5/4/15 = 208.8 5/5/15 = 206.9 5/6/15 = 210.1 5/7/15 = 208.4 5/8/15 = 206.1 5/11/15 = 207.4 5/12/15 = 207.5 5/13/15 = 210.1 5/14/15 = 210.9 5/15/15 = 209.4 5/16/15 = 212.4 5/18/15 = 212.8 5/19/15 = 211.5 5/20/15 = 206.6 5/21/15 = 206 5/25/15 = 209.4 5/26/15 = 210.5 5/28/15 = 206.8 5/29/15 = 208.5			

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	155220		06/03/2015

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	The record lacked documentation to indicate the resident was weighed on the following dates: 4/9, 4/11, 4/12, 4/13, 4/15, 4/16, 4/17, 4/18, 4/19, 4/22, 4/23, 4/25, 4/26, 4/27, 5/2, 5/3, 5/9, 5/10, 5/17, 5/22, 5/23, 5/24 and 5/27/15. An interview with the DON on 6/1/15 at 3:44 p.m., indicated the CNAs who do the weights are aware of parameters for each resident based on their orders, they should reweigh the resident if there was a discrepancy, then notify the nurse who should in turn notify the Physician and document in the progress notes. Daily weights should be done as indicated in the Physician Orders. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to the	F 0309	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	06/17/2015

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	monitoring and assessment of skin related to bruising for 2 of 3 residents reviewed for non-pressure related skin conditions of the 4 residents who met the criteria for non-pressure related skin conditions. (Residents #24 and #17) 1. During an observation of Resident #24 on 5/27/15 at 8:45 a.m., a golf ball sized purplish discoloration was noted to the back of her right hand by her thumb. The resident indicated at the time of the observation, "I hit them all the time on the doorways when I'm pushing my wheelchair around." Resident #24 was observed on 5/28/15 at 8:33 a.m., sitting in her wheelchair in her room with her gown on, waiting for her shower. Purple discolorations remained to the back of her right hand. Resident #24 was observed on 6/1/15 at 8:49 a.m., sitting in her wheelchair in her room. A purple discoloration to back of her right hand remains, fading slightly. Resident #24 was observed on 6/1/2015 at 9:00 AM with the East Unit Manager (UM), who noted a purple discoloration/ bruise to the resident's right hand. An interview at the time of the observation with the East UM indicated she did not remember any recent bruises to that area		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F309** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident R17 is as follows: A bruise event was completed for R17 and reported to the physician. The corrective action for resident R24 is as follows: A bruise event was completed for R24 and reported to the physician. **How the facility will identify other residents having the potential to be affected by the**	

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	being monitored. She further indicated skin impairments, including bruising, were usually noted on shower days by the CNAs, but they were also instructed to visualize the resident's skin with daily care and report any issues to their staff nurse who would then type an event note on the computer. The UM also indicated she printed out all events each morning for the previous day and reviewed them, charting herself when an issue is resolved. An interview with CNA #3 on 6/2/15 at 10:50 AM, indicated Resident #24 was a limited assist for ADL's (Activities of Daily Living) and staff helped her get her clothes out and stood by to assist if needed. An interview with the DON (Director of Nursing) on 6/2/15 at 11:07 AM, indicated when CNAs had orientation and inservices, they were made aware to observe resident's skin during daily care and report any issues to the nurse. Resident #24's record was reviewed on 6/1/15 at 10:45 AM. Diagnoses included, but were not limited to, anemia, Parkinson's, COPD (Chronic Obstructive Pulmonary Disease, a breathing disorder), and weakness.		**same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Skin sweeps were completed to identify any new alterations in skin integrity. An event was completed for any new alterations and the physician notified **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · During ADL and/or showers observe for any alterations in skin integrity, such as bruises, rash, skin tears, wounds, scratches, etc. Report immediately to the nurse. The nurse must complete the appropriate event/observation as well as measure and describe the observation in Matrix. Notify the	

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	A review of current Physician Orders included monitoring for bruising on the left lower arm, left shin, right lateral upper arm, right forearm, and right posterior arm every shift until resolved. A review of the Progress Notes included assessments on 5/20/15, 5/21/15, 5/24/15 and 5/29/15 of healing specifically to bruises on the resident's left shin, left lower arm, right lateral upper arm, right forearm and right posterior arm. There was no documentation indicating bruising to the back of the resident's right hand near her thumb. Care plans were in place for a risk for impaired skin integrity r/t (related to) a history of bruises, scratches, and skin tears r/t fragile skin, anemia, decreased mobility and Parkinson's and for a risk for skin breakdown. Interventions included, but were not limited to, monitor bruises as ordered, report any deterioration in status of bruising to physician and responsible party, and monitor skin during daily routine care and notify charge nurse if any changes in skin. The record lacked documentation of any monitoring of bruising or discoloration to the resident's right hand.		physician and appropriate family/legal representative. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, 6 residents will have skin observations completed. If skin alterations are observed the clinical record will be reviewed to determine if a skin event has been completed and the physician notified. If the event was not found, one will be completed immediately so monitoring can be started, and the physician notified. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	

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	2. During an observation of Resident #17 on 5/27/15 at 9:57 AM, dark purplish, puffy discolorations were noted to both hands and forearms. At the time of the observation, the resident indicated he bumped them all the time on the doorjambs when moving his wheelchair around. He also indicated he bruised easily, had thin skin, and took a long time to heal due to his diabetes. On 5/28/15 at 8:38 AM, Resident #17 was observed sitting in his wheelchair in his room reading the newspaper and watching TV. Long sleeves were noted and dark purple discolorations remain to his hands. On 5/29/15 at 10:25 AM, Resident #17 was observed sitting in his wheelchair in his room. Discolorations remained to the back of both hands. Resident #17 was again observed on 6/1/2015 at 8:40 AM with the East Unit Manager (UM), who noted purple discolorations/ bruises to the back of the resident's hands and a currently wrapped skin tear to his right wrist. An interview on 6/1/15 at 8:47 AM with the East UM indicated Resident #17 previously had bruises to the back of both			

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	hands which were completely gone and closed out by her. He did have an issue with constant bruising. She further indicated she did not see anything charted regarding bruises to his hands since 5/20/15 when those were closed out, so the ones observed to his hands now were new. An interview on 6/2/15 at 10:16 AM with the DON, indicated she was aware of the new bruising not previously identified for Resident #17 and a new skin assessment had been completed. An interview on 6/2/15 at 10:46 AM with CNA #2, indicated Resident #17 was an extensive assist for ADLs including dressing. Staff helped him get started with his clothes and he did what he could from there. She further indicated if she ever noticed any skin areas during daily care for any resident, she passed it along to the nurse to assess. A follow up interview with the DON on 6/2/15 at 11:07 AM, indicated when CNAs have orientation and inservices, they are made aware to observe resident's skin during daily care and report any issues to the nurse. Resident #17's record was reviewed on 5/28/15 at 9:09 AM. Diagnoses included,			

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	but were not limited to, cardiomyopathy, peripheral vascular disease, diabetes mellitus, anemia, muscle weakness, and sleep apnea. Current Physician Orders included Coumadin (a medication which thins the blood and causes a risk of bleeding or bruising) 2 mg (milligrams) 1 tab oral once a day and monitor bruising to the left abdomen, right AC (inner elbow), right humerus, right inner arm, and lower humerus every shift until healed. Care plans were in place for impaired skin integrity related to skin tears and bruising, receives daily coumadin and for a risk for skin breakdown. Interventions included, but were not limited to, monitor each bruise q (every) shift until resolved, and monitor skin during daily routine care and notify charge nurse if any changes in skin are noted. A policy titled "Measurement, Assessments of Pressure Ulcers, Wounds and Other Skin Problems" was provided by the DON (Director of Nursing) on 6/1/15 at 1:10 PM and deemed as current. The policy indicated, "1. At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and describe skin condition in the clinical record...3. Skin			

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	conditions other than ulcers, such as bruises, skin tears, abrasions, rashes, excoriations will be described upon initial observation and documented ...." 3.1-37(a)			
F 0312 SS=D Bldg. 00	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, record review, and interview, the facility failed to ensure each resident who were dependent on staff received oral care on a daily basis for 1 of 3 residents reviewed for Activities of Daily Living (ADLS) of the 3 who met the criteria for ADLS. (Resident #66) Finding includes: An interview on 5/27/15 at 12:29 p.m. with Resident #66's daughter indicated the staff do not brush her mother's teeth. On 5/29/15 at 7:05 a.m., Resident #66 was observed in bed. At that time, the resident was awake. The resident was able to open her mouth and her teeth	F 0312	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F312** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	06/17/2015

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	were observed. The resident had discolored bottom teeth and there was a moderate amount of food debris noted in between the teeth. On 5/29/15 at 8:22 a.m., the resident was still observed in bed. The resident was again able to open her mouth and the same food debris was observed in the bottom teeth. At 8:24 a.m., CNA #1 entered the room and indicated to the resident that she was going to get her up for breakfast. The CNA wet two washcloths and provided incontinence care for the resident. She then placed an incontinence brief on the resident and pulled up her pants. The CNA indicated at that time, she had to get the lift and another staff member to help her get the resident out of the bed. She then left the room and returned with the lift and another CNA. Both CNAs helped the resident to the side of the bed and removed her hospital gown. Neither CNA washed the resident's upper body at that time. CNA #1 dressed the resident by placing a sweatshirt on her and then placed the sling around the resident for the sit to stand lift. The resident was then seated in her wheelchair. At that time, CNA #1 combed the resident's hair and got another washcloth wet and handed it to the resident to wash her face. The CNA did not offer or provide oral care to		The corrective action for resident **R66** is as follows: R66 was taken to the room and oral care provided. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents that are dependent on staff for oral care have the potential to be affected by the same alleged deficient practice. Care cards were audited to ensure level of care for hygiene and oral care were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · Hygiene and oral care are	

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	the resident. The CNA then pushed the resident out of the room, down to the main dining room to eat breakfast. On 5/29/15 at 10:04 a.m. the resident was observed in the main dining room. The resident again opened her mouth and her bottom teeth had food debris noted in them. Interview with CNA #1 on 5/29/15 at 12:55 p.m., indicated AM care included washing the resident's peri area real good and their face. The CNA indicated the resident would not allow her to brush her teeth, however, the CNA was not observed to even try or attempt to brush the resident's teeth. The record for Resident #66 was reviewed on 6/01/15 at 8:48 a.m. The resident's diagnoses included, but were not limited to, syncope, high blood pressure, fall, macular degeneration, debility, muscle weakness, and cognitive impairment. The Quarterly Minimum Data Set (MDS) assessment dated 3/31/15 indicated the resident was not alert and oriented. The resident had no behavior problems, rejection of care, or other mood problems. The resident was an extensive assist with one person physical assist for		to be provided to any resident who needs assistance or who is dependent on staff when they get up and when they go to bed. Some residents are able to complete hygiene/oral care themselves after being set up with the supplies, such as wash cloth, bath basin, toothpaste, tooth brush, etc. Review the care card to determine the type of assistance they need. If you observe the resident needs more help than is specified on the care card, alert nursing so an evaluation can be made and appropriate changes made. If the resident declines any type of care, notify nursing immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, the Director of Nursing/designee will observe oral care on three (3) residents to determine if proper care/assistance was provided. Re-education will be provided to the aid at that time for any improvement needed. The care card will also be checked to ensure proper coding of assistance needed, and changes made to the care at that time if level of care has changed.	

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	personal hygiene. Review of the current plan of care updated 3/2015 indicated there was no care plan addressing personal hygiene and oral care. The 3/30/15 ADL Functional Analysis Assessment was incomplete. The previous ADL Functional Analysis Assessment dated 1/26/15 indicated under the section for Personal Hygiene the resident was an extensive assist for brushing teeth. Interview with the Director of Nursing on 6/1/15 at 10:30 a.m., indicated the CNA should have at least attempted to brush the resident's teeth during AM care. She further indicated AM care consisted of oral care and teeth brushing. 3.1-38(a)(3)(C)		A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	
F 0322 SS=D Bldg. 00	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and			

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	(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure medications were administered properly through a Percutaneous Endoscopic Gastrostomy (PEG) tube and placement was verified and checked prior to the administration of medications for 1 of 1 residents observed with a PEG tube during medication pass. (Resident #24) Finding includes: On 6/01/2015 1:00 p.m., LPN #1 was observed preparing medication for Resident #24. The LPN crushed one oral medication and kept the substance in the plastic bag. She then poured a liquid medication into a plastic med cup. The LPN entered the resident's room with the medications. She turned the enteral feeding on hold and attached the syringe to the PEG tube and checked for residual. She did not check for placement of the PEG tube with a stethoscope and air bolus prior to the medication administration. She flushed the PEG tube with 30 cubic centimeters (cc) of water first and then poured the crushed	F 0322	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to**	06/17/2015

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	dry medication directly into the syringe. The medication was not diluted. She poured 5 cc of water into the syringe and swirled it back and forth so it would go down. The LPN poured water into the plastic bag to try and get the residual of the medication out of the bag, after doing this she swirled the medication back and forth in the bag and then poured the substance in the syringe. She followed with another 10 cc water flush and then poured the liquid medication into the syringe for administration. Interview with LPN #1 on 6/1/15 at 1:14 p.m., indicated she had always prepared and administered oral medications through a PEG as above. She indicated "I just pour the contents of each crushed pill out of the plastic bag directly into the syringe without diluting first. The LPN indicated she was unaware of the facility's policy on how to administer medications through a PEG tube. The Enteral Medication Administration Policy was reviewed on 6/1/15 at 1:30 p.m. The policy "Tablets are crushed and capsules are opened to facilitate mixing and administration. Tablets should be crushed to fine consistency. Powder from crushed tablets, or capsule contents should be dispersed well in 15-20 milliliters of water or other prescribed		**the regulatory requirement.** **F322** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident **R24** is as follows: R24 had no negative effects from the placement not being checked and the meds given inappropriately. Upon notification by surveyor E1 was immediately re-educated and counseled. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with a PEG tube have the potential to be affected by the same alleged deficient practice. All residents with enteral feedings had their orders checked to ensure they have a check placement order on the Medications Administration Record. Orders were generated for those who did not have one. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th,	

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	diluent. All particles must be in solution prior to administering the medication. Check for correct placement of feeding tube prior to administration of medication." Interview with the Evening Shift Supervisor on 6/1/15 at 1:30 p.m., indicated the LPN did not administer the medication correctly according to the facility's policy. 3.1-44(a)(2)		2015 by Director of Nursing/designee regarding the following: · ENTERAL MEDICATIONS – Wash hands and apply gloves for this procedure. An order must be present to give medications through the tube. An order must also be present to crush meds. Check medications for those that CANNOT be crushed. Physician will need to be called for an alternative. Do not mix medications together, each must be given separately. Crushed tablets are dissolved in 15 – 20ml of water. Capsule are to be emptied into 10ml of water. Liquids are to be diluted in 10ml of water (Viscous medications can be dissolved in 15-30ml of warm water prior to administration). Turn off the feeding if running. Check stomach for residual (check order to identify when to notify physician….usually 100 – 150cc). Check for placement by instilling 10cc of air and listening for “whoosing” sound. Flush with 30ml of water. Administer medication one at a time with at least 5ml of water between medications. Pour any liquids into syringe and allow to flow to gravity. Rinse medication cup with water and re-administer to ensure all of the ordered medication was given. After all meds have been given, flush with 30ml of water. Reconnect feeding if it was running. Ensure resident HOB is	

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			at 30 – 45 degrees **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, the Director of Nursing/designee will observe the medication pass for three (3) residents on alternating shifts weekly to ensure proper technique and placement was provided. Education will be provided to the nurse for any inappropriate observations. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	
F 0371 SS=E Bldg. 00	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 and interview the facility failed to ensure food was served under sanitary conditions related to serving uncovered dessert bowls below	F 0371	**Please accept the following**	06/17/2015

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	waist level for 1 of 3 dining rooms observed, this had the potential to affect 75 residents. The facility also failed to ensure room trays were delivered to residents in a sanitary way related to serving trays uncovered down the hallway from room to room for 2 of 4 hallways observed, this had the potential to affect 16 residents. (The Main dining room and the East Unit) Findings include: 1. On 5/26/15 at 11:59 a.m., in the Main dining room, the dessert cart was observed being parked outside of the kitchen doors to the right of the steam table servery. The dessert bowels were observed on the top and middle shelves uncovered. Interview at the time with Activity Aide #1 indicated the dessert bowels contained chocolate mousse and/or pudding. At 12:21 p.m., Activity Aide #1 was observed pushing the dessert cart throughout the dining room as she served the desserts to the residents. The desserts were served to the residents from the cart below waist level. Interview with the Dietary Manager on 5/26/15 at 12:31 a.m., indicated the desserts should have been covered before		**as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **F371** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The facility residents did not have any negative effects	

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	they were delivered from the kitchen to the dining room. She also indicated the Activity Aide should not have served the uncovered desserts from the cart below waist level throughout the dining room. 2. During a lunch service dining observation on the East Unit on 5/26/15 beginning at 11:50 a.m., four unit staff members were serving lunches to residents from the room tray cart. At 11:52 a.m., staff carried a tray from the cart at the front of the rooms 126-137 hall halfway down the hall to room 128 with uncovered pudding. At 11:53 a.m., staff carried a tray from the cart part way down the hall to room 127 with uncovered pudding. At 11:54 a.m., staff carried a tray from the cart part way down and across the hall to room 126 with uncovered pudding. The cart was then pushed over to the rooms 118-125 hallway and at 11:57 a.m., staff carried a tray from the cart part way down the hall to room 123 with uncovered pudding. The cart was moved again to the middle of the rooms 107-117 hallway.		from the food not being covered prior to serving. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Containers/food not yet served were covered. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · Serving and transporting meal trays and food items – all food items should be covered when transporting down the hallway. If you observe an item that is not covered, prior to transporting, ask the kitchen for a cover. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, the Director of Nursing/designee will observe three (3) different dining room meal times to ensure all food items were covered during tray pass. The dietary department will be alerted immediately be the auditor if items were observed served uncovered so corrections can be made. A summary of	

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	At 12:00 p.m., staff carried a tray part way down the hall to room 115 with pudding uncovered. At 12:03 p.m., staff carried a tray part way down the hallway to room 108 with an uncovered fruit dish. At 12:04 p.m., the East Unit Manager (UM) carried a tray with uncovered applesauce and pudding all the way down the hall to room 116. At 12:04 p.m., staff carried a tray with uncovered pudding from the cart in the middle of the room 107 hall all the way around the nurses' station to room 127. An interview with the East UM on 5/26/15 at 12:07 p.m., indicated none of the sides or desserts on the trays she passed had lids and all should have - dietary should be providing lids on the trays. An interview with QMA #1 on 5/26/15 at 12:09 p.m., indicated none of the desserts or sides on the trays she passed out to residents in their rooms had lids. An interview with the Dietary Manager on 5/27/15 at 3:00 p.m., indicated all food being carried down the hallways should be covered.		the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	

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	A policy titled "Tray Service" was presented by the Dietary Manager on 5/27/15 at 3:20 p.m. and deemed as current. The policy indicated, ".... All foods will be protected during transportation. Any trays transported outside of an enclosed cart will have all items covered." 3.1-21(i)(3)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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			

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	keys. 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. Based on observation, record review, and interview, the facility failed to ensure the label on an eye drop medication had the correct instructions for use for 1 of 8 residents observed during medication pass. (Resident #14) Finding includes: On 5/29/15 at 6:25 a.m., LPN #2 was observed preparing medication for Resident #14. At that time, she removed a bottle of AKWA Tears 1.4% (a natural tear eye drop medication) from the medication cart. The label on the bottle indicated place 2 drops in each eye four times a day. On 6/02/15 at 12:45 p.m., the Director of Nursing removed the container of the eye medication. At that time, the label of eye medication was observed to be the same as above.	F 0431	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F431** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident **R14** is as follows: R14 had a Direction Change sticker placed on the label. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. All medication orders on the Medication Administration Record (MAR) were reviewed against the label on the container.	06/17/2015

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	The Medication Administration Record (MAR) for the month of May and June 2015 were reviewed. The Physician Order dated 5/11/15 indicated the resident was to receive 2 drops into the right eye not both eyes. Interview with the DON on 6/2/15 at 1:32 p.m., indicated the ordered had been changed on 5/11/15, however, the label did not reflect the new order and should have been changed. 3.1-25(k)(5)		A Direction Change Sticker was placed on any container that did not match the MAR order. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · Medication labels and orders – Prior to giving any medication, eye drop, nebulizer, insulin, etc. the label must be checked against the order on the MAR. If the order does not match, check what is listed in Matrix and determine which one matches the order in Matrix. If the label on the medication is incorrect, place a 'Direction Change Sticker' over the instruction section on the medication container. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, the Director of Nursing/designee will observe the medication pass for three (3) residents on alternating shifts who receive eye drops to ensure the label matches on the eye drops and all other meds on the MAR. A Direction Change Sticker will be placed immediately if they do not match. A summary of the audits will be presented to the Quality Assurance committee monthly by	

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			Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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. (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			

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	their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure every employee washed their hands immediately after glove removal and wore gloves for the administration of eye medication for 1 of 1 residents observed during AM care and for 1 of 1 residents observed during eye medication administration. (Residents #14 and #66) Findings include: 1. On 5/29/15 at 6:25 a.m. LPN #2 was observed preparing eye drop medication for Resident #14. The LPN entered the resident's room and instructed the resident to open both of her eyes so she could administer the eye drops. The LPN administered 2 eye drops into each eye. During the procedure the LPN did not wear gloves to either one of her hands and administered the medication with her bare hands. Interview with LPN #2 on 5/29/15 at 6:30 a.m., indicated she was supposed to wear gloves while administering eye	F 0441	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F441** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident **R66** is as follows: R66 had no negative effects from the aids hands not being washed after gloves removed. The corrective action for resident **R14** is as follows: R14 had no negative effects from not wearing gloves during eye drop administration. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Staff re-education was provided after the event. Rooms	06/17/2015

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	drops. Interview with the Director of Nursing on 6/1/15 at 10:30 a.m., indicated the LPN should have worn gloves to administer the eye drop medication. 2. On 5/29/2015 at 8:22 a.m. Resident #66 was observed in bed wearing a hospital gown. At 8:24 a.m., CNA #1 entered the room to provide AM care for the resident. The CNA placed clean gloves on her hands and got a washcloth wet to provide incontinence care. She provided incontinence care and placed an incontinent brief on the resident. She then pulled up her pants and indicated at that time, she had to get the lift so the resident could get out of bed. She removed her gloves and threw them away in the garbage can. She removed the garbage bag, tied it shut and then got another plastic bag and placed the soiled linens in that bag. She then walked out of the room. The CNA threw one plastic bag into the soiled linen container in the hall and the other bag into the trash container in the hall. She continued to walk down the hall to the other side of the Nurse's station and grabbed the lift as well as another CNA to help her. She did not wash her hands with soap and water or use alcohol gel to either one of her hands after she had removed her		were checked to ensure gloves were available in each room. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · EYE DROP/OINTMENT MEDICATION – Wash hands and apply gloves. Position dropper over the eye for administration, have them look upward and with the other hand pull down the lower eye lid. Instill the drop inside the lower eyelid close to the outer corner. Do not instill medication directly on the cornea. For ointments, apply a thin line of ointment along the conjunctival surface of the retracted lower lid with the tip of the ointment tube. Release the eyelid and instruct to gently close the eye and not to squeeze eye shut. Wipe excess solution with tissue from inner to outer canthus using clean tissue for each eye. When two or more different eye solutions must be administered at the same time, allow five minutes between them. If more than one drop of the same eye medication is ordered at the same time, wait one minute before instilling the second drop. · After any ADL and/or peri-care, gloves should be removed and then hands washed immediately prior to exiting the room. **How the**	

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	gloves. She returned to the room with the lift. CNA #1 placed another pair of clean gloves on her hands and got the resident into her wheelchair. She removed her gloves and combed the resident's hair. She walked out of the room and grabbed a clean washcloth and towel off of the linen cart in the hallway and came back into the room. She still had not washed her hands with soap and water. She got the wash cloth wet with water so the resident could wash her face. The resident washed her face and handed the wash cloth back to the CNA. The CNA bagged the dirty linen into a plastic bag and wheeled the resident out of the room, threw away the soiled linen and pushed the resident to the dining room. The CNA did not wash her hands with soap and water after she removed her gloves. Interview with CNA #1 on 5/29/15 at 12:55 p.m., indicated she was unaware she did not wash her hands after she removed the gloves and after providing incontinence care. The current 11/20/13 Hand Washing/Hand Hygiene policy was reviewed. The policy was provided by the Administrator. The policy indicated employees must wash their hands with soap and water or use an alcohol based		**corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly, the Director of Nursing/designee will observe peri-care for five (5) residents on alternating shifts to ensure proper peri-care was provided and hands were washed afterward. Education will be provided to the aid immediately for any inappropriate observations. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	

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DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

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	hand gel after removing gloves. Interview with the Director of Nursing on 6/1/15 at 10:30 a.m., indicated the CNA should have washed her hands after removing the gloves. 3.1-18(b)(1)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to gouged and marred walls and doors, dirty floors, walls and cove bases, rusty sink drains, cracked floor tile, peeling wall paper, bent shelves, and holes in walls on 2 of 2 units and 1 of 3 dining rooms throughout the facility. (The Main kitchen and the West Unit dining room) Findings include: During the Environmental Tour on 6/3/15 at 12:25 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed:	F 0465	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F465** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	06/17/2015

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	1. West Unit a. Room 107-1, the front of the bathroom door was marred. Two residents shared that bathroom. b. Room 124-1, the corner guards of the bathroom door were loose and contained sharp edges. Two residents shared that bathroom. c. Room 125-2, the bottom of the bathroom door was gouged and marred, the door guards were loose and contained sharp edges. Two residents shared that bathroom. d. Room 134-2, the bottom of the bathroom door was gouged and marred. Two residents shared that bathroom. 2. East Unit a. Room 155-1, the entry door was marred and the night stand was scratched and marred. Two residents shared that room. b. Room 156-1, the bathroom floor was dirty. There was an accumulation of dirt along the cove bases. The caulking around the toilet was dirty. The plaster over the sink was cracked and the plaster underneath the soap dispenser was		The corrective actions were as follows: ·Room 107-1 bathroom door marred was repaired with a kick plate. ·Room 124-1 corner guards of the bathroom door installed. ·Room 125-2 bottom of the bathroom door was repaired with a kick plate. The door guards are in process of being installed. ·Room 134-2 bottom of the bathroom door was repaired with a kick plate. ·Room 155-1 entry door marred was repaired with a kick plate, and night stand scratches and marks repaired. ·Room 156-1 bathroom floor was cleaned including the cove bases. The caulking around the toilet was cleaned. The plaster over the sink and underneath the soap dispenser were repaired. ·Room 160-1 wall next to closet was repaired, electrical plate cover replaced, wallpaper underneath the window repaired, and the metal shelf underneath the bathroom was repaired ·Room 179-1 bathroom sink drain repaired. ·Room 188-1 bathroom floor tile around toilet was cleaned. ·The West Dining Room silver electrical outlet covers were replaced, table legs were cleaned, and the lower bases of the walls were cleaned.	

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	missing and painted over. Two residents shared that bathroom. c. Room 160-1, the wall next to the closet was marred. There was an electrical face plate cover over the cable outlet which exposed a hole underneath the cable outlet. The wallpaper underneath the window was peeling. The metal shelf underneath the bathroom mirror was bent and the bathroom door was gouged and marred. Two residents resided in the room and two residents shared that bathroom. d. Room 179-1, the bathroom sink drain was rusty. Two residents shared that bathroom. e. Room 188-1, the bathroom floor tile around the toilet was cracked and discolored. One resident used that bathroom. 3. The West Dining Room The silver electrical outlet covers were rusty and covered with food splatter. The table legs were dirty and covered with food spillage. The lower bases of the walls were dirty and covered with food spillage. Interview with the Maintenance and		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Repairs that could be done immediately were addressed right after the inspection. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th, 2015 by Director of Nursing/designee regarding the following: · Work orders are available at each of the nurse's station to alert maintenance of any needed repairs. Identify what the issue is and the location. Maintenance will check the nurse's station daily and prioritize the needed repairs.	

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	Housekeeping Supervisors at 1:09 p.m., indicated all the above were in need of cleaning and/or repair. 3.1-19(f)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Monthly, the Maintenance Director/designee will inspect 10 rooms on each unit for needed repairs. Repairs will be prioritized and any repairs requiring items to be bought will be reported to the administrator for approval. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	

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F 0494 SS=D Bldg. 00	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.			
	Based on record review and interview the facility failed to ensure 1 employee who had worked in the facility as a CNA had obtained their CNA certification within 120 days of their hire date. (Employee #1) Findings include: The facility Employee Files were reviewed on 6/2/15 at 10:00 a.m. The following Employee had not completed	F 0494	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F494**	06/17/2015

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	the CNA certification. Employee #1 Hired as a CNA on 11/7/14 and terminated on 4/1/15. Worked as a CNA past the 120 days on 3/18/15, 3/24/15, 3/25/15, 3/26/15, and 3/28/15. Interview with the Human Resource Supervisor on 6/2/15 at 2:00 p.m., indicated she would go through the license and certificate book monthly to see if anyone had expired or was in need of getting a CNA certificate. She further indicated she had realized her system was not very good and some staff could get missed depending on the time of the month she goes through the book and/or her associate may file a certificate of completion of the CNA class after she had already gone through the book. This Federal Tag relates to Complaint IN00171835. 3.1-14(b)(2)(A) 3.1-14(b)(2)(B) .		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The C.N.A. is no longer employed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. There were no negative effects from the aid being on the schedule past the 120 day period. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-serviced held on June 12th,	

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			2015 by Director of Nursing/designee regarding the following: · C.N.A. licensed certification – A C.N.A. has 120 days to obtain their certification. If they are unable to obtain their certification, they will need to be removed from the schedule until this requirement is fulfilled. · Administrator educated Human Resources regarding the requirements of the regulation **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Twice monthly, Human Resources will review the email notification alerts of upcoming expirations of C.N.A. certifications. Human Resources will contact the employee that they will be removed from the schedule on a specified date if no certification is obtained by that date. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for	

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			three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date Certain: June 17, 2015**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 46 Residential Sample: 9 These State findings cited in accordance with 410 IAC 16.2-5.	R 0000	Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the			

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	overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.			

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	(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview the facility failed to inform the State Agency within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. (Resident #8) Finding includes: The record for Resident #8 was reviewed on 6/2/15 at 2:43 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's and dementia without behaviors. Review of the Residential Service Plan last updated on 2/4/15 indicated, "Resident keeps going outside in the snow and ice even though being told he shouldn't go outside". Review of the Sheffield Manor Functional Assessment last updated on 3/16/15 indicated the resident's mental status was moderately impaired. Continued review of the comments section indicated, "Resident starting to wander away from facility, can't	R 0090	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **R090** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective action for resident **8** is as follows: R8 was discharged from the facility. **How the facility will identify**	06/17/2015

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	remember how to get back". The Nursing Note dated 2/4/14 indicated the following, " At 11:30 a.m., resident has increased confusion and seems agitated, keeps talking about his mother and wants to know where she is....also spoke with son about possible alternative placement to an Alzheimer's facility if confusion with behaviors continue. Resident keeps going outside when he is told it's not safe because of the snow and ice, he likes to walk around the building outside. Have had to bring him back inside several times." Review of the Nursing Notes indicated on 3/13/15 at 8 a.m., "Resident walked out of the building and couldn't find his way home.....Last evening resident took a walk up the street with no sidewalks and was observed in a gas station parking lot by Munster Police Officer. Resident looked confused and lost so the Officer approached him and engaged in conversation, then realized the resident had dementia. The resident had a friend's phone number in his pocket so the officer was able to contact the friend to find out where the resident lived. The officer returned the resident home. The resident stated it got black outside and he couldn't find his way home".		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. The clinical records were reviewed to determine if any other events required reporting. None were noted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** In-service was held on 12th by Resident Care Coordinator/designee with Sheffield Manor staff regarding the following: 1. Events which require Indiana State Department of Health to be notified 2. Any events that fall under the reporting requirements will be reporting within the timeframes specified by the State 3. All reportable events will be	

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	Interview with the LPN Care Coordinator on 6/2/15 at 3:19 p.m., indicated the incident was reported to her Administrator who contacted the Corporate Office. Interview with the Administrator on 6/2/15 at 3:51 p.m., indicated the facility felt the resident was safe and it just so happened the police were at the gas station at the time. She further stated she thought during that time the resident would have been able to find his way home. Continued interview indicated she was not fully aware of the resident's cognition and/or level of confusion.		discussed with the Administrator **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Daily, all events will be reported to the Resident Care Coordinator by the nurse. The Resident Care Coordinator will discuss with the Administrator any possible reportable events and ensure they were reported per the timeframe guidelines. If any events were not reported that meet the guidelines, the event will be reported to ISDH immediately by the Resident Care Coordinator. A summary of the observations will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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