

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2013
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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 28, 29, 30, 31 and November 1, 2013.</p> <p>Facility number : 000044 Provider number : 155106 AIM number: 100274940</p> <p>Survey team: Michelle Hosteter, RN-TC Janet Stanton, RN Gloria Bond, RN Bobbie Messman, RN</p> <p>Census bed type : SNF/NF: 143 Total : 143</p> <p>Census payor type: Medicare: 9 Medicaid : 110 Other : 24 Total : 143</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on November 8, 2013.</p>	F000000	<p>The creation and submissions of the Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statemetrn of deficiencies, or of any violation of regulation. This Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests desk review for paper compliance in lieu of post survey visit on or after Nov 30, 2013</p>	

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

TITLE

(X6) DATE

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

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation and record review, the facility failed to complete hygiene care for a resident as indicated by the care plan for 1 of 3 residents reviewed for assistance with activities of daily living. (Resident #43)</p> <p>Findings include:</p> <p>The record review for Resident #43 was completed on 10/30/13 at 1:00 p.m. The MDS (minimum data set) assessment dated 9/17/13 indicated the resident was totally dependent on staff to assist her with her hygiene.</p> <p>The care plan dated 1/12/11 indicated the resident would be assisted with all activities of daily living, such as hygiene by staff.</p> <p>On 10/28/2013 at 12:33 p.m., the resident was observed to have yellow/white matter stuck to her eyelids. The resident's hair was uncombed and frizzy in appearance.</p> <p>The physician's recapitulation for</p>	F000282	<p>F282 Services per Care Plan - It is the consistent practice of this Provider to complete hygiene care for a resident as indicated by the care plan.1. What corrective action has been taken for each client/resident cited in alleged deficiency? Resident #43 was provided with appropriate hygiene including hair care and eye care as directed by the care plan. The resident physician assessed this resident and increased current treatment for the eye to better manage the blepharitis in the eye. 2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency?All residents residing in the facility have the potential to be affected by the alleged deficient practice. Facility wide rounds were completed by the nurse managers to review and ensure consistent care was provided to each resident as directed by plan of care. Any issue found was immediately corrected with the resident, the resident care sheet and the plan of care.3. What changes will be taken by this Provider to ensure the alleged deficient</p>	11/30/2013			

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	<p>October indicated an order dated 3/2/13, "... Johnson Baby shampoo wash eyelids/lash scrubs daily in the morning due to blepharitis...."</p> <p>The resident was observed on 10/31/13 at 10:26 a.m. The resident's right eye was slightly open, but the left eye was shut and was observed to have yellow matter stuck to her eyelashes. The resident's hair was uncombed and sticking up in the back.</p> <p>3.1-35(g)(2)</p>		<p>practice does not recur? Nursing staff were re-inserviced on this Providers expectation of providing quality compassionate care consistant with the plan of care and needs of the residents by the DNS/designee on 11/21/13. Charge nurses will complete care rounds daily each shift to ensure consistent care is being provided to each resident. Nurse managers will round daily to monitor and assess care be provided to each resident is consistent with the plan of care. Resident care representatives will continue to visit their assigned residents each day to assist in daily monitoring of care and customer service.4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur? The DNS/designee is responsible for the completion of the Care Plan review CQI tool weekly times 4 weeks, bi-monthly times 2 months, and monthly x 4 months, then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to provide daily hygiene care to a dependent resident for 1 of 3 residents reviewed for activities of daily living. (Resident # 43)</p> <p>Findings include :</p> <p>The record review for Resident #43 was completed on 10/30/13 at 1:00 p.m. The MDS (minimum data set) assessment dated 9/17/13 indicated the resident was totally dependent on staff to assist her with her hygiene.</p> <p>On 10/28/2013 at 12:33 p.m., the resident was observed to have yellow/white matter stuck to her eyelids. The resident's hair was uncombed and frizzy in appearance.</p> <p>The chart was reviewed and the physician's recapitulation for October indicated an order dated 3/2/13, "...Johnson Baby shampoo wash eyelids/lash scrubs daily in the morning due to blepharitis...."</p>	F000312	F 312 ADL Care for Dependent residents - It is the consistent practice of this Provider to assist and provide daily hygiene care to each and every dependent resident. 1. What corrective action has been taken for each client/resident cited in alleged deficiency? Resident #43 was provided with appropriate hygiene including hair care and eye care as directed by the care plan. The wheelchair for resident #43 was thoroughly cleaned and sanitized, eliminating the urine odor. The resident physician assessed this resident and increased current treatment for the eye to better manage the blepharitis in the eye. 2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency? All residents residing in the facility have the potential to be affected by the alleged deficient practice. Facility wide rounds were completed to review and ensure consistent hygiene ADL care was provided to each resident as directed by plan of care and that personal equipment was clean	11/30/2013			

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	<p>The resident was observed on 10/31/13 at 10:26 a.m. The resident's right eye was slightly open, but the left eye was shut and was observed to have yellow matter stuck to her eyelashes. The resident's hair was uncombed and sticking up in the back.</p> <p>The resident was observed on 10/31/13 at 4:30 p.m. The resident's right eye had a light yellow matter on her right eye. The left eye was shut and had little bits of yellow particulate matter stuck to the eye lid.</p> <p>In an interview with LPN #4 on 10/31/13 at 4:35 p.m., she indicated the resident had her eyes cleaned twice a day.</p> <p>The CNA (Certified Nursing Aide) worksheet for Hall I indicated, "...Resident #43 Shower Day shift...Wednesdays and Saturdays 6-2 don't wash hair!...."</p> <p>In an interview on 11/1/13 at 2:10 p.m., CNA #17 indicated the resident typically had a very strong urine. She indicated the resident had an odor of urine soon after they clean her up. She indicated they do not wash her hair because the beauty shop does it.</p>		<p>and sanitary. Any issue found was immediately corrected with the resident, the resident care sheet and the plan of care.3. What changes will be taken by this Provider to ensure the alleged deficient practice does not recur? Nursing staff were re-inserviced on this Providers expectation of providing quality compassionate care consistant with the plan of care and needs of the residents by the DNS/designee on 11/21/13. Charge nurses will complete care rounds daily each shift to ensure appropriate care is being provided to each resident and that personal equipment is clean and sanitary. Nurse managers will round daily to monitor and ensure appropriate ADL and hygiene care is provided to each resident. Resident care representatives will continue to visit their assigned residents each day to assist in daily monitoring of care and customer service.4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur? The DNS/designee is responsible for the completion of the Nurse rounds checklist tool weekly times 4 weeks, bi-monthly times 2 months, and monthly x 4 months, then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these</p>				

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	<p>In an interview with LPN #16 on 11/1/13 at 2:25 p.m., she indicated the last day the beautician was here was October 17th, however her schedule is Monday, Wednesday, and Friday from 10:00-3:30 p.m.</p> <p>In an interview on 11/1/13 at 3 p.m., LPN #4 indicated they were not certain of the last time the resident had her hair washed. She indicated the family was very clear they do not want the CNA's washing the hair only the beautician.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(b)(3)</p>		<p>audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review the facility failed to ensure hand sanitation procedures were followed during 2 pressure ulcer dressing changes. This impacted 1 of 1 residents observed for pressure ulcer dressing changes in a sample of 2 residents reviewed for pressure ulcer care. (Resident # 160).</p> <p>Findings include:</p> <p>On 10/31/13 at 10:15 A.M., RN #1 was observed while performing 2 pressure ulcer wound dressing changes for Resident #160. During the pressure ulcers wound care and dressing change observation, RN # 1 was observed cleansing one pressure ulcer wound, changing gloves, applying a new dressing to the wound, changing gloves, cleansing the second pressure ulcer, changing</p>	F000314	F314 Treatment and services to prevent and heal pressure sores - It is the consistent practice of this Provider to ensure proper sanitation procedures are completed during dressing/treatment changes.1. What corrective action has been taken for each client/resident cited in alleged deficiency? Resident #160 is receiving pressure wound care following the proper procedure for hand sanitation during dressing changes.2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency?All residents with wounds have the potential to be affected by the same alleged deficient practice. All residents with wounds were assessed and reviewed by the DNS/designee to ensure proper hand sanitation procedures were followed during dressing changes. Nursing staff have	11/30/2013			

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	<p>gloves, applying a new wound dressing to the second pressure ulcer, and changing gloves without hand sanitizing her hands between glove changes.</p> <p>On 10/31/13 at 4:05 P.M., the Clinical Education Coordinator provided the facility's document titled, " Dressing Change...Nursing Policy & Procedure...." dated 09/2012, and the facility's document titled, " Standard Precaution Usage Guidelines...." dated 10/2011.</p> <p>The facility's Dressing Change section: Nursing Policy & Procedure indicated, "...Cleanse away debris or drainage from the wound...Remove gloves and discard. Perform hand hygiene. Put on gloves...."</p> <p>The facility's Standard Precaution Usage Guidelines indicated, "...Hand washing or Alcohol based hand rubs (ABHR)...after removing or changing gloves during a procedure,...."</p> <p>During an interview on 10/31/13 at 4:07 P.M., the Clinical Education Coordinator indicated the facility's documents provided are the nursing policy and procedures as well as guidelines that their nurses are to follow. The morning observation</p>		<p>been re-educated on the proper infection control procedures in providing care and treatment by the Clinical Education Coordinator on 11/13/13. 3. What changes will be taken by this Provider to ensure the alleged deficient practice does not recur?Nursing staff have been re-educated on the proper infection control procedures in providing care and treatment by the Clinical Education Coordinator. DNS/designee will conduct rounds on each shift to ensure proper hand sanitation procedures for dressing changes is being followed. 4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur?Wound dressing change validation check will be completed daily for one week on each shift by DNS/designee, bi-weekly for one week, weekly times 2 weeks and monthly for 6 months. Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved, an action plan will be developed to ensure compliance.</p>				

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	indicated these were not followed. 3.1-40(a)(2)				

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F000323 SS=E	<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.</p> <p>Based on observation, interview and record review, the facility failed to ensure there were no elevated and potentially hazardous water temperatures at resident bathroom sinks and in common Activity/Dining areas accessible to residents. This deficiency impacted 7 rooms checked for hot water temperatures of 23 rooms on the Alzheimer's Memory Care 1 and Memory Care 2 units, and at the sink in 1 of 2 common Activity/Dining rooms on those units.</p> <p>Findings include:</p> <p>On 10/29/13, during the Stage 1 data-gathering portion of the annual survey, water temperatures greater than the acceptable range of 100-120 degrees F. (Fahrenheit) were obtained using a digital thermometer at the bathroom sinks in the following rooms on the Alzheimer's Memory Care 1 and 2 units.</p> <p>Memory Care 1:</p>	F000323	F323 Free of Accidents / Hazards - This Provider consistently ensures that there are no elevated or potentially hazardous water temperatures.1. What corrective action has been taken for each client/resident cited in alleged deficiency? The hot water lines were immediately turned off and drained for Memory Care units I and II. The water mixing valve was immediately fixed. The hot water tested within the acceptable temperature range.2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency? All residents residing on Memory Care I and II have the potential to be affected by the alleged deficient practice. The hot water lines were immediately turned off and drained. The water mixing valve was immediately fixed. Maintenance Staff were re-educated on 10/31/13 by the Executive Director on the company's preventative maintenance schedule related to the consistent monitoring and logging of water temperatures to	11/30/2013			

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	<p>10:05 A.M./Room 116--134 degrees F.</p> <p>10:10 A.M./Room 123--130 degrees F. In an interview at that time, one of the 2 residents in the room indicated the water temperature seemed OK to her; she had not been scalded or burned.</p> <p>10:12 A.M./Room 119--130 degrees F. Maintenance Assistant #18 was working in the bathroom at that time, and indicated he thought water temperatures were checked monthly. He indicated the Maintenance Director "may do something more."</p> <p>10:18 A.M./Room 118--135 degrees F.</p> <p>Memory Care 2:</p> <p>10:23 A.M./Room 107--129 degrees F.</p> <p>10:27 A.M./Room 104--134 degrees F.</p> <p>10:31 A.M./Room 111--130 degrees F.</p> <p>In an interview on 10/29/13 at 11:15 A.M., the Maintenance Director indicated he performed water temperature checks daily--selecting one room randomly on each side of each hall. He indicated he checked all of the sinks that would be accessible to the residents. He indicated he had 4 water heaters in</p>		<p>ensure resident safety. The Maintenance Director checked water temperatures throughout the building at all faucets to ensure hot water was at the appropriate temperature.3. What changes will be taken by this Provider to ensure the alleged deficient practice does not recur? The maintenance department will monitor and test water temperatures through out the building, random rooms on each hall, each day to ensure water temperatures are within appropriate ranges. Upon any identification of inappropriate temperatures, the Maintenance staff will take immediate correction based on the need of the current findings. These temperatures will be logged each day and will be systematically taken as directed by the Preventative Maintenance schedule. 4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur?The Executive Director will monitor this system. The Maintenance Director will provide the water temperature logs to the Executive Director weekly x4, and then monthly for at least 6 months to validate and sign that the monthly preventative maintenance has occurred and documented.</p>		

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	<p>the facility, one of which served Memory Care units 1 and 2. The water heater/mechanical room was located at the entrance of the Memory Care 1 unit. He indicated the temperature gauge was difficult to read due to lighting in the room, and because the gauge was turned around to face the rear of the room. He indicated he had checked Memory Care unit resident rooms 109 and 115 this morning, and the water temperatures were within the acceptable range.</p> <p>On 10/29/13 at 11:45 A.M., the water heater serving the Memory Care units was observed. The temperature gauge was facing opposite direction, and toward the dark end of the small room. The water heater and other associated equipment was crammed in the small room, making it difficult to go around the water heater to actually see and read the gauge.</p> <p>In an interview at that time, the Maintenance Director indicated no one had said anything to him or the Maintenance Assistant about hot water temperatures.</p> <p>In another interview at that time, the Director of Nursing indicated she had not had any incidents of residents</p>						

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	<p>being scalded or burned by hot water over the past 6 months.</p> <p>In an interview on 10/29/13 at 11:50 A.M., the Maintenance Director indicated he had checked the water temperatures about 6:00 A.M., but had not yet recorded them. At that time, he was requested to provide for review any of his logs or other documentation with water temperatures for the previous 6-month period.</p> <p>In an interview on 10/29/13 at 11:55 A.M., LPN #14 indicated she did not notice any difference this morning while she was washing her hands. In an interview on 10/29/13 at 11:56 A.M., LPN #20 indicated she had not noticed any problem with hot water today; however, she never fully turns on the hot water, but always turns on the cold water at the same time.</p> <p>In an interview on 10/31/13 at 10:00 A.M., CNA #15 indicated she usually works on the Memory Care 1 unit. On the morning of 10/29/13, she had given 3 residents a shower. She indicated she always checks water temperature against her inside forearm, and adjusts accordingly. She indicated the shower water control is a dial, and she does not</p>			

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	<p>turn it all the way around for hot water. She did not notice any problem with excessively hot water that morning.</p> <p>On 10/29/13 at 11:57 A.M., the water at the Activity/Dining room kitchenette sink on the Memory Care 1 unit was at 128 F.</p> <p>In an interview on 10/29/13 at 12:00 P.M., the Maintenance Director indicated there was a mixing valve problem with the Memory Care unit water heater, and the lime buildup was preventing the valve from being loosened. The hot water for the unit was now turned off, and he was in the process of letting all of the hot water out of the heater.</p> <p>The Maintenance Director indicated he was unable to locate the water temperature check logs at this time, and that other Maintenance staff may have them. However, both employees were out of the building. He indicated he had written water temperatures on a yellow legal pad for both yesterday and today (10/28 and 10/29/13), and would provide that for review.</p> <p>In an interview on 10/29/13 at 12:27 P.M., the Executive Director indicated</p>						

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	<p>that Maintenance Director wrote down temperatures on a yellow pad of paper. They would make copy of each page and bring those and the temperature logs for review.</p> <p>The documentation of water temperature checks for 10/28/13 listed 16 resident rooms throughout the facility, and 4 common dining areas (including both Memory Care unit dining rooms) had been checked that day. No time was listed. All temperatures for all resident rooms and 2 dining rooms were documented as within a range of 109 to 116 degrees F. There were no water temperatures listed for the Memory Care 1 and 2 units. The documentation of water temperatures for 10/29/13 listed 15 resident rooms throughout the facility, and 4 common dining areas. All water temperatures were documented within a range of 109 to 118 degrees F.</p> <p>In an interview on 10/29/13 at 12:49 P.M., the Maintenance Director indicated he had started documenting water temperatures on 10/28/13, when the annual survey started. He indicated he did not have any documentation of water temperature checks for more than 10/28 and 10/29/13.</p>			

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	3.1-45(a)(1)			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to monitor blood pressures for a resident with a history of labile (unstable) high blood pressure, for 1 of 5 residents reviewed for unnecessary medications. (Resident #49)</p> <p>Findings include:</p> <p>The resident review was completed 10/31/13 at 11:30 a.m. Diagnoses</p>	F000329	F329 Unnecessary Drugs - It is the practice of this Provider to monitor blood pressure for residents with history of unstable high blood pressure as directed by a physician.1. What corrective action has been taken for each client/resident cited in alleged deficiency? Resident #49 blood pressure was taken and was within normal ranges. The physician staff reviewed resident #49 care to ensure no adverse outcomes have occurred.2. How will this Provider identify other residents being affected by the	11/30/2013			

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	<p>included, but were not limited to, end stage renal disease, high blood pressure, and history of stroke.</p> <p>The resident was in the hospital 9/4/13 through 9/6/13 due to signs of increased blood pressure and possible stroke.</p> <p>The physician recapitulation dated 9/1/13-9/30/13 indicated, "...blood pressure taken pre and post dialysis every Monday, Wednesday, and Friday and record in EMR [Electronic Medical Record] [labile HTN] [7/24/13...."</p> <p>The resident's care plan dated 6/27/13 for end stage renal disease indicated, "... Medications and labs per order, ... record blood pressure after return from dialysis...."</p> <p>The MAR (Medication Administration Record) for September and October 2013 indicated the blood pressure had not been taken on the following dates which were Monday, Wednesday and Friday :</p> <p>9/2- 6-2 shift and 2-10 shift 9/4- 2-10 shift 9/9- 2-10 shift 9/11- 2-10 shift 9/13- 2-10 shift 9/16- 2-10 shift</p>		<p>same alleged practice and what action taken to correct this alleged deficiency? All residents with Blood Pressure orders have the potential to be affected by the alleged deficient practice. A complete audit of each resident with BP orders was completed by the nurse managers to ensure the residents' blood pressure was being taken and recorded as ordered. The physician was notified if the BP reading was outside the normal range.3. What changes will be taken by this Provider to ensure the alleged deficient practice does not recur? Nursing staff was re-educated by the DNS/designee on 11/12/13 on following physician orders, specifically taking blood pressure. DNS/designee will audit the MAR's daily for documentation of BP's per physician order. The physician will be notified if the BP reading is outside the normal range. 4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur?To ensure compliance, the DNS/designee is responsible for the completion of the Medical Records CQI tool weekly x 4, bi-monthly x 2, monthly x4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen</p>				

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	<p>9/18- 2-10 shift 9/20- 2-10 shift 9/23- 2-10 shift 9/25- 6 -2 shift and 2-10 shift 10/7- 2-10 shift 10/11-2-10 shift 10/16- 2-10 shift 10/18- 2-10 shift</p> <p>In an interview on 10/31/13 at 3:15 p.m., LPN #19 indicated she works this hall on a regular basis and Resident #49 gets her blood pressure done once a day.</p> <p>The Director of Nursing indicated in an interview on 11/1/13 at 11:40 a.m., she observed the second shift had not been documenting blood pressures for Resident #49 on a regular basis.</p> <p>3.1-48(a)(3)</p>		by the ED. If threshold is less than 95%, an action plan will be developed to ensure compliance.	

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rates of 5 % or greater. During the medication pass observation, 2 errors were made in an total of 30 opportunities, for an error rate of 6.67 %. This deficiency impacted 2 of 6 residents observed receiving medications during the medication pass task. (Residents #199 and 201)</p> <p>Findings include:</p> <p>1. On 11/1/13 at 8:31 A.M., RN #13 was observed to dispense and administer medications to Resident #199. The nurse dispensed six medications: Losartan, Metoprolol, Daily Vitamin, Omeprazole, Zetia, and Sertraline. Before taking the medication to the resident, the nurse confirmed she had 6 pills in the medication cup.</p> <p>At 8:35 A.M., a reconciliation was done between the medications ordered and the medications given to Resident #199. On 10/15/13, the physician gave an order for Cardizem</p>	F000332	<p>F332 Med Errors - It is the consistent practice of this Provider to ensure that nursing staff is free from medication errors of rates of 5% or more.1. What corrective action has been taken for each client/resident cited in alleged deficiency? Resident #199 - This resident was given the Cardizem that same morning as directed; there was no negative effect. Resident #201 - was assessed by the physician nurse practitioner and proper dosage given as ordered.2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency? All residents receiving medications have the potential to be affected by the alleged deficient practice. Licensed nursing staff were re-educated on proper med pass procedure by the Clinical Education Coordinator on 11/12/13. All licensed nursing staff had a skills validation check-off completed by the DNS/designee for med pass procedure to ensure physicians' orders are followed. 3. What changes will be taken by this Provider to ensure the alleged deficient practice does not recur?</p>	11/30/2013	

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	<p>CD 180 mg. (milligrams) ER (Extended Release) 1 by mouth every day--scheduled for 9 AM. The medication was listed on the MAR (Medication Administration Record). However, it was not observed to be given at the time of the medication pass, and would have increased the number of pills in the cup to 7.</p> <p>In an interview on 11/1/13 at 9:42 A.M., RN #13 indicated she was not sure what happened to the Cardizem. She pulled the blister card containing the medication from the cart, and indicated, after seeing the capsule (a vivid bright turquoise and blue color), that it had not been given. She then dispensed the medication and gave it to the resident at that time.</p> <p>The record for Resident #199 was reviewed on 11/1/13 at 11:45 A.M. Diagnoses included, but were not limited to, hypertension and atrial fibrillation. Blood pressure readings were documented as follows: 10/19=172/80; 10/21=154/70; 10/21=126/52; 10/22=148/80; 10/23=128/84; 10/25=130/68; 10/26=130/58; 10/28=140/86; 10/29=118/64; 10/30=122/64; and 10/31=120/62.</p> <p>2. On 11/1/13 at 8:39 A.M., LPN #12</p>		<p>Licensed nursing staff were re-educated on proper med pass procedure by the Clinical Education Coordinator on 11/12/13. The DNS/designee will observe a med pass on each shift daily to ensure the physician orders are followed as ordered.4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur? Med pass skills validation check off will be completed on all shifts daily for one week, bi-weekly for 1 week, weekly x 2 weeks and then monthly x 6 months by the DNS/designee. Results of the skills validations will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved, an action plan will be developed to ensure compliance.</p>				

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	<p>was observed dispensing and administering medications to Resident #201. Each pill blister on a card labeled Metoprolol (a blood pressure medication) contained 1/2 tablets. The nurse was observed to punch out one of the 1/2 tablets and place in the medication cup.</p> <p>At 9:00 A.M., a reconciliation was done between the medications ordered and medications given to Resident #201. An order on 10/26/13 changed the dosage of Metoprolol from 12.5 mg. (1/2 tab) to 25 mg. (1 whole tablet). The MAR (Medication Administration Record) listed the change, but the pill card did not have an "Order Change" tag. At 9:10 A.M., LPN #12 confirmed she only gave 1/2 tablet (12.5 mg.).</p> <p>The record for Resident #201 was reviewed on 11/1/13 at 10:36 A.M. Diagnoses included, but were not limited to, senile dementia- -Alzheimer's type, angina pectoris, tricuspid valve disease, hypertension, history of acute myocardial infarction and coronary heart disease.</p> <p>Blood pressure readings were documented as follows: 10/24/13=198/86, 188/100, 184/94, and 198/110; 10/26/13=208/90 and</p>			

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	<p>202/100; 10/29/13=204/108; 10/30/13=196/88; 10/31/13=210/100; and 11/1/13=186/98 and 200/100.</p> <p>In an interview on 11/1/13 at 12:00 P.M., the Nurse Practitioner indicated the resident has had issue with an elevated blood pressure for some time, and that she was going to see him today.</p> <p>3.1-25(b)(9)</p>			

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F000371 SS=C	<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 and interview, the facility failed to ensure the cleanliness of the equipment and air flow unit in 1 of 1 kitchen observed for cleanliness. This deficient practice had the potential to effect 139 of 143 residents residing in the facility and receiving food from the kitchen.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen with the Dietary Manager and Dietician on 10/28/13 at 9:30 a.m., the following items were observed:</p> <p>1 The air flow unit located across and above the stove area and warmers was dirty and full of dust and debris. The Dietary Manager opened the air flow unit and it was observed to have a dirty air filter.</p> <p>2. The flat top grill had grease, rust and debris located along the edges of the grill.</p>	F000371	F371 Food store/prepare/serve sanitary - It is the consistent practice of this Provider to ensure the cleanliness of the equipment and air flow within the kithchen. 1. What corrective action has been taken for each client/resident cited in alleged deficiency? The Air flow unit (air condiontion unit) was immediately cleaned including vents and air filters.The flat top grill has been removed from the kitchen.The clean dish rack has been replaced with new rack.2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency? All residents have the potential to be affected by the alleged deficient practice. All kitchen equipment was checked by the Dietary Manager to ensure it was in good repair.The Air flow unit (air condiontion unit) was immediately cleaned including vents and air filters. The flat top grill has been removed from the kitchen.The clean dish rack has been replaced with new rack.3. What changes will be taken by this Provider to ensure the alleged	11/30/2013			

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	<p>3. The clean dish rack had a dark brown rust residue in each slotted area where clean dishes were in place.</p> <p>During an interview with the Dietary manager and the Dietician, on 10/28/13, at 9:45 a.m., they indicated that the air flow unit, clean dish rack and flat top grill needed to be cleaned.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>deficient practice does not recur? The dietary staff was inserviced by the RD on proper cleaning schedules, identifying and assessing conditions of equipment and the expectation of this Providers expectations of a clean sanitary kithchen.4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur?The RD will be responsible to ensure a Kitchen sanitation QA/report will be completed weekly x4, and monthly thereafter for at least 6 months to ensure proper and ongoing kithen sanitation. If threshold of 95% is not achieved, an action plan will be developed to ensure consistent compliance.</p>		

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F000441 SS=E	<p>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.</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.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	F441 Infection Control - It is the consistent practice of this	11/30/2013			

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	<p>ensure 2 of 3 nurses observed used appropriate infection control techniques to obtain and use blood sugar finger-stick test strips, to prevent possible cross-contamination. This impacted 3 of 4 residents observed for blood sugar testing with a glucometer. In addition, the facility failed to ensure appropriate hand sanitizing procedures were used between glove use, for 1 resident observed during a dressing change; for 1 of 2 residents reviewed for pressure ulcers. (Residents #52, #85, #200, and #160; and LPNs #3 and #11)</p> <p>Findings include:</p> <p>1. On 10/30/13 at 4:22 P.M., LPN #11 was observed while performing a blood sugar glucometer test for Resident #52. After sanitizing the glucometer and obtaining supplies, the nurse put on disposable gloves and went into the resident's room. She wiped the resident's finger with alcohol pad, and used the lancet to obtain blood bead. The nurse did not touch puncture site or roll resident's finger. With same gloves, she opened test strip bottle, took out a strip, and placed it in the glucometer. After obtaining the blood, the nurse wiped the resident's finger with an</p>		<p>Provider to ensure appropriate infection control practices to obtain and use blood sugar test strips; proper infection control for dressing changes. 1. What corrective action has been taken for each client/resident cited in alleged deficiency?Residents #52, #200 and #85 received blood sugar glucometer tests following correct infection control procedures.Resident #160 is receiving .pressure wound care following the proper procedure for hand sanitation during dressing changes.2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency?All residents with wounds have the potential to be affected by the same alleged deficient practice. all residents requiring blood sugar testing have the potential to be affected by the alleged deficient practice. All residents with wounds were assessed and reviewed by the DNS/designee to ensure proper hand sanitation procedures were followed during dressing changes. Nursing staff have been re-educated on the proper infection control procedures in providing care and treatment by the Clinical Education Coordinator. Licensed nursing staff had a skills validation check for blood sugar glucometer testing and wound dressing change completed by the DNS/designee. 3. What</p>				

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	<p>alcohol pad.</p> <p>2. On 10/30/13 at 4:39 P.M., LPN #11 was observed while performing a blood sugar glucometer test for Resident #200. The nurse used hand sanitizer, put on disposable gloves, then pushed code pad with her gloved finger to open medication cart. She touched several different items on the top of the cart with her gloved hand, and after obtaining supplies went into the resident's room. The nurse wiped the resident's finger with an alcohol wipe, then used the lancet to get a blood bead. She did not touch the puncture site, or roll or manipulate the resident's finger. With the same gloves, the nurse opened the test strip bottle and took out a strip. She placed it in glucometer. After obtaining the blood, the nurse wiped the resident's finger with an alcohol pad.</p> <p>3. On 10/31/13 at 11:40 A.M., LPN #3 was observed while performing a blood sugar glucometer test for Resident #85. The nurse obtained the bottle of test strips, a lancet, the glucometer, alcohol wipes and paper towels. She went into the resident's room and placed the glucometer on paper towels on the over-bed table. She put on disposable gloves,</p>		<p>changes will be taken by this Provider to ensure the alleged deficient practice does not recur? Nursing staff have been re-educated on the proper infection control procedures in providing care and treatment by the Clinical Education Coordinator on 11/13/13. DNS/designee will conduct rounds on each shift to ensure proper hand sanitation procedures for Blood glucose testing and dressing changes is being followed. 4. How will the corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur? The Infection control QA and Wound dressing change validation check will be completed daily for one week on each shift by DNS/designee, bi-weekly for one week, weekly times 2 weeks and monthly for 6 months. Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved, an action plan will be developed to ensure compliance.</p>				

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	<p>opened the test strip bottle, and took out one test strip, which she placed in the glucometer. The nurse wiped the resident's finger with an alcohol pad, and used the lancet to obtain a blood bead. There was only a small blood bead, so the nurse rolled/manipulated the resident's finger. Unable to get enough blood to saturate the test strip pad, the nurse pulled test strip out of glucometer and put it back in a couple of times, touching the pad end of the test strip. She decided to get another test strip, so she discarded first strip, then using same gloves, got another strip from bottle and put in glucometer. After obtaining enough blood to run the test, she wiped the resident's finger with alcohol pad.</p> <p>In an interview on 10/31/13 at 11:55 A.M., LPN #3 indicated the facility's Policy and Procedure was to put the test strip into glucometer first before doing the finger stick. If it was necessary to obtain a second test strip, gloves should be changed before reaching into the bottle of test strips. She indicated she would discard the bottle of test strips because the remainder were possibly contaminated.</p> <p>4. On 10/31/13 at 10:15 A.M., RN #1</p>			

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	<p>was observed while performing 2 pressure ulcer wound dressing changes for Resident #160. During the pressure ulcers wound care and dressing change observation, RN # 1 was observed cleansing one pressure ulcer wound, changing gloves, applying a new dressing to the wound, changing gloves, cleansing the second pressure ulcer, changing gloves, applying a new wound dressing to the second pressure ulcer, and changing gloves without hand sanitizing her hands between glove changes.</p> <p>On 10/31/13 at 4:05 P.M., the Clinical Education Coordinator provided the facility's document titled," Dressing Change...Nursing Policy & Procedure...." dated 09/2012, and the facility's document titled," Standard Precaution Usage Guidelines...." dated 10/2011.</p> <p>The facility's Dressing Change section: Nursing Policy & Procedure indicated, "...Cleanse away debris or drainage from the wound...Remove gloves and discard. Perform hand hygiene. Put on gloves...."</p> <p>The facility's Standard Precaution Usage Guidelines indicated, "...Hand washing or Alcohol based hand rubs</p>			

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	<p>(ABHR)...after removing or changing gloves during a procedure,...."</p> <p>During an interview on 10/31/13 at 4:07 P.M., the Clinical Education Coordinator indicated the facility's documents provided are the nursing policy and procedures as well as guidelines that their nurses are to follow. The morning observation indicated these were not followed.</p> <p>5. In an interview on 10/31/13 at 12:00 P.M., the Director of Nursing indicated LPN #11 reported she (the nurse) later realized she had incorrectly handled the test strips, with possible contamination, and had discarded the vial with the test strips.</p> <p>The Director of Nursing indicated "Nursing Skills Validation" review for the use of q glucometer and blood sugar testing had recently been completed for all licensed nursing staff. Validation forms for LPN #3 were dated 6/21/12 and 10/23/13. Validation forms for LPN #11 were dated 8/12 and 10/22/13.</p> <p>The form, titled "Glucose Meter Cleaning and Testing," with the most recent review date of 03/2013, included, but was not limited to, the following information:</p>			

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	<p>"... 14. Place clean paper towel, plastic cup or clean barrier on hard surface.</p> <p>15. Place cleaned meter on paper towel, in plastic cup or clean barrier.</p> <p>16. Put on clean gloves.</p> <p>17. Cleanse resident's finger tip with alcohol wipe.</p> <p>18. Allow finger tip to air dry.</p> <p>19. Insert reagent strip into meter.</p> <p>20. Prick resident's finger tip with lancet.</p> <p>21. Obtain single droplet of blood...."</p> <p>3.1-18(b)(1) 3.1-18(l)</p>			

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F000465 SS=E	<p>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.</p> <p>Based on observation and interview the facility failed to maintain resident rooms, equipment, and common area in clean orderly state of good repair for 4 of 35 rooms reviewed for environmental cleanliness and repair. (Rooms #204, #224, and #229, and common area Moving Forward Dining area.)</p> <p>This deficient practice impacted 30 out of 30 residents.</p> <p>Findings include:</p> <p>1. On 10/28/13, 10/29/13 and 10/30/13, the following was observed:</p> <p>a.) The entrance door to room # 204 would not close properly, the door was difficult to open when it was closed, and the door hinges were observed to have the screws loose in the hinge socket.</p> <p>b.) The toilet in room #224 was observed to be leaning to the left.</p> <p>c.) The large arm chair in the Moving Forward dining area was observed to</p>	F000465	F465 Safe/Functional/comfortable environment - It is the consistent practice of this Provider to maintain resident rooms, equipment, and common areas in a a clean orderly state of repair.1. What corrective action has been taken for each client/resident cited in alleged deficiency? Room 204 door was immediately tightened and corrected.Room 224 toilet was tightened and corrected.Moving Forward arm chair has been cleaned and sanitized.Room 229 / Resident #43 wheel chair was cleaned immediately.Surveyors were provided with an extensive list of construction that also addressed these areas in the environment of remodeling each and every room including replacement of doors, toilets, flooring, furniture, wheelchairs - and much more, all to improve the overall environment of each resident. The Surveyors acknowledged this work was already in progress.2. How will this Provider identify other residents being affected by the same alleged practice and what action taken to correct this alleged deficiency?All residents have the potential to be affected by the alleged deficient	11/30/2013

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	<p>have many spots/stains on the seat and arm rests.</p> <p>During an interview on 10/29/13 at 10:00 a.m., with the Maintenance Manager, he indicated the facility was in the process of renovation. He also indicated that room #204, the door needed immediate repair.</p> <p>During an interview on 11/1/2013 at 3:30 p.m., with RN # 13 indicated the large arm chair in the Moving Forward dining area did have spots and stains and needed to be cleaned.</p>		<p>practice. Staff were re-educated in ensuring we provide a safe/functional/clean environment by the Clinical Education coordinator on 11/21/13. All resident rooms and common areas were inspected to ensure room and furniture were clean and in proper working order by the ED/designee. Surveyors were provided with an extensive list of construction that also addressed these areas in the environment of remodeling each and every room including replacement of doors, toilets, flooring, furniture, wheelchairs - and much more, all to improve the overall environment of each resident. The Surveyors acknowledged this work was already in progress.3. What changes will be taken by this Provider to ensure the alleged deficient practice does not recur? Staff were re-educated in ensuring we provide a safe/functional/clean environment by the Clinical Education coordinator on 11/21/13. Construction and remodeling that is currently underway will eliminate many of these allegations of concerns. Room rounds will occur daily by management team with their assigned rooms to assist in identifying any environmental issues or equipment repairs needed. Work orders will be turned in when an issue is identified.4. How will the</p>	

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	<p>2. In an observation on 10/28/13 at 12:33 p.m., a strong urine odor was noted when walking into Resident #43's room.(Room #229)</p> <p>On 10/31/13 at 12:08 p.m., room #229 was noted to have a very strong smell of urine in it. Resident #43's wheel chair was noted have a very strong odor of urine.</p> <p>In an interview on 11/1/13 at 2:10 p.m., CNA (Certified Nursing Aide) #17 indicated that Resident #43 typically has a very strong urine odor. She indicated the resident had an odor soon after they clean her up. She also indicated they have a cleaning schedule for the wheel</p>		<p>corrective action be monitored or quality assurance program implemented to ensure the alleged deficient practice will not recur?The ED/designee is responsible for the completion of the Environmental CQI tool weekly times 4 weeks, bi-monthly times 2 months, and monthly x 4 months, then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

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	<p>chairs which nights does, but that if the resident wets the chair they clean it up with sanitation wipes. She also indicated she noticed the resident's wheel chair had a strong odor of urine.</p> <p>The Social Services Director provided an untitled and undated document on 11/1/13. He indicated the document was the cleaning schedule for the residents in Hall I and their wheelchairs. The document indicated, "...Wheel chair cleaning schedule is as follows ..Wednesdays...229...."</p> <p>In an interview on 11/1/13 at 2:30 p.m., with LPN #4 (unit manager for Hall I) she indicated she did not have any documentation that indicated when the wheel chair cleaning schedule was completed, only the list indicating when it needed to be done.</p> <p>3.1-19(f)</p>			

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