

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 11, 12, 13, 14 and 15, 2016</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicare: 2 Medicaid: 18 Other: 8 Total: 28</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on July 22, 2016.</p>	F 0000	Please consider this POC to serve as our credible allegation of compliance	
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS			

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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	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure allegations of abuse were reported immediately to the</p>	F 0225	F225 1) What corrective action(s) will be accomplished for those residents found to have been affected by the	08/14/2016

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	<p>Administrator for 2 of 3 abuse allegations reviewed. (Residents #1 and #17)</p> <p>Findings include:</p> <p>1. The staff to resident abuse investigation for Resident #1 was reviewed on 7/14/16 at 11:38 a.m. The investigation indicated on 4/14/16 at approximately 1:30 p.m., the resident reported to the Administrator and the Social Worker that he wanted to have his neck x-rayed or an ultrasound. He indicated on "Monday" an incident had occurred in his room with a Nurse. He said he had quoted something he had seen on Facebook that was in Spanish and he did not know what it meant. One of the 2 CNA's (Certified Nursing Assistants) in the room heard it, one knew what it meant and told him it was a negative statement referring to someone's mother. The resident indicated the Nurse then "grabbed my head and jerked it to the left and told me don't you ever talk about my mother like that and disrespect her."</p> <p>The two CNA's reported to the Director of Nursing (DON), on 4/12/16, the date of the incident. The DON talked to the LPN who was accused and the resident. No further investigation was initiated at this time.</p>		<p>deficient practice? Resident#1 received the x-ray for his neck and results were negative. Resident #17 has requested she not be touched in order to wake her up, she prefers to be woken up verbally only, so it is care planned that resident be woke up verbally. Resident #1 and #17 will now have any abuse allegation investigated immediately following immediate notification to Administrator 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected, so all Staff will be re-educated on the Facility Abuse Policy and Procedure. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will receive re-education on the Facility Abuse Policy and Procedure. Staff will be in-serviced on the facility grievance protocol as well. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? All grievances will be reported to Administrator immediately and reviewed in Morning Meeting for compliance. Grievances will be discussed</p>	

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	<p>An investigation was not started by the Administrator until 4/14/16, two days after the incident.</p> <p>Interview with the Administrator on 7/15/16 at 2:50 p.m., indicated that she was to be notified immediately of any allegation of abuse.</p> <p>2. The record for Resident #17 was reviewed on 7/13/16 at 10:00 a.m. The resident's diagnoses included, but were not limited to, stroke with left side weakness, diabetes and hypertension.</p> <p>The Grievance log for the month of April 2016 was reviewed. On 4/18/16, the resident indicated a Nurse "poked" her to wake her up. The grievance was documented by the Social Service Designee.</p> <p>A Social Service progress note, dated 4/19/16, indicated the resident notified the Social Service Designee (SSD) that the Nurse came into her room and poked her to wake her up on Saturday. The SSD notified the Administrator and an investigation was initiated.</p> <p>Interview with the Administrator on 7/15/16 at 2:50 p.m., indicated that she was to be notified immediately of any</p>		<p>daily until a resolution has been achieved. The Admin or designee will interview 5 random interviewable, residents weekly for 6 months to ensure compliance with reporting allegations/grievances is maintained. Deficient areas will be corrected immediately. Results will be presented to QA Committee for further review and any recommendations. 5) When will the systemic changes be completed? 8-14-16.</p>				

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F 0226 SS=D Bldg. 00	<p>allegation of abuse.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility implemented their policy to report allegations of abuse immediately to the Administrator for 2 of 3 abuse allegations reviewed. (Residents #1 and #17)</p> <p>Findings include:</p> <p>1. The staff to resident abuse investigation for Resident #1 was reviewed on 7/14/16 at 11:38 a.m. The investigation indicated on 4/14/16 at approximately 1:30 p.m., the resident reported to the Administrator and the Social Worker that he wanted to have his neck x-rayed or an ultrasound. He indicated on "Monday" an incident had occurred in his room with a Nurse. He</p>	F 0226	<p>F226 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#1 received the x-ray for his neck and results were negative. Resident #17 has requested she not be touched in order to wake her up, she prefers to be woken up verbally only, so it is care planned that resident be woke up verbally. Resident #1 and #17 will now have any abuse allegation investigated immediately following immediate notification to Administrator 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected, so all</p>	08/14/2016

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	<p>said he had quoted something he had seen on Facebook that was in Spanish and he did not know what it meant. One of the 2 CNA's (Certified Nursing Assistants) in the room heard it, one knew what it meant and told him it was a negative statement referring to someone's mother. The resident indicated the Nurse then "grabbed my head and jerked it to the left and told me don't you ever talk about my mother like that and disrespect her."</p> <p>The two CNA's reported to the Director of Nursing (DON), on 4/12/16, the date of the incident. The DON talked to the LPN who was accused and the resident. No further investigation was initiated at this time.</p> <p>An investigation was not started by the Administrator until 4/14/16, two days after the incident.</p> <p>Interview with the Administrator on 7/15/16 at 2:50 p.m., indicated that she was to be notified immediately of any allegation of abuse.</p> <p>2. The record for Resident #17 was reviewed on 7/13/16 at 10:00 a.m. The resident's diagnoses included, but were not limited to, stroke with left side weakness, diabetes, and hypertension.</p>		<p>Staff will be re-educated on the Facility Abuse Policy and Procedure. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will receive re-education on the Facility Abuse Policy and Procedure. Staff will be in-serviced on the facility grievance protocol as well. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? All grievances will be reported to Administrator immediately and reviewed in Morning Meeting for compliance. Grievances will be discussed daily until a resolution has been achieved. The Admin or designee will interview 5 random interviewable, residents weekly for 6 months to ensure compliance with reporting allegations/grievances is maintained. Deficient areas will be corrected immediately. Results will be presented to QA Committee for further review and any recommendations. 5) When will the systemic changes be completed? 8-14-16.</p>				

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	<p>The Grievance log for the month of April 2016 was reviewed. On 4/18/16, the resident indicated a Nurse "poked" her to wake her up. The grievance was documented by the Social Service Designee.</p> <p>A Social Service progress note dated 4/19/16, indicated the resident notified the Social Service Designee (SSD) that the Nurse came into her room and poked her to wake her up on Saturday. The SSD notified the Administrator and an investigation was initiated.</p> <p>Interview with the Administrator on 7/15/16 at 2:50 p.m., indicated that she was to be notified immediately of any allegation of abuse.</p> <p>The Abuse and Neglect policy was provided by the Administrator, on 7/13/16 1:00 p.m., and identified as current. The policy indicated the following: The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility.</p> <p>3.1-28(c)</p>			

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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure medically-related social services were provided related to arranging dental visits for 1 of 3 residents reviewed for dental services of the 10 who met the criteria for dental services. (Resident #1)</p> <p>Finding includes:</p> <p>On 7/12/16 at 11:10 a.m., Resident #1 was observed with broken and carious teeth. The resident indicated that he would like to see a dentist to get his teeth pulled.</p> <p>The record for Resident #1 was reviewed on 7/12/16 at 1:58 p.m. The resident's diagnoses included, but were not limited to, anemia, quadriplegia and allergies.</p> <p>A Dental progress note, dated 2/24/16,</p>	F 0250	<p>F250 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#1 has appointment with Dentist on August 5th. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? Audit of all residents to determine if any residents due for or in need of dental services. Any residents identified will be placed on list to see dentist. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Any residents who missed their dental appointments will automatically be placed by Social Services on the list for the next scheduled Dentist visit. Prior to the Dental visit, the list will be reviewed at</p>	08/14/2016

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	<p>indicated tooth pain was reported by the resident. Emergency visit done today 2/24/16. Resident was complaining of tooth pain. Tooth #31 is broken and throbbing, causing discomfort. Referral for extraction of tooth #31 per resident's request. No visible infection or sores. Follow up in three months.</p> <p>There was no documentation in the resident's record related to follow up for the tooth extraction. The resident's last dental visit was on 2/24/16.</p> <p>Interview with the MDS (Minimum Data Set) Coordinator, on 7/15/16 at 11:00 a.m., indicated the resident was sent to the hospital, on 2/25/16, and returned on 2/28/16. She indicated the resident then had a Physician's order to transfer home, however, the resident did not transfer home due to home health service issues. She indicated the referral must have gotten "missed" due to the resident being in the hospital and then the possibility of being sent home.</p> <p>Interview with the Social Service Designee on 7/15/16 at 10:45 a.m., indicated the last time the dentist was in the facility, the resident was in the hospital. She indicated the resident was on the list to be seen by the Dentist on 7/25/16.</p>		<p>morning meeting for review with the ID team to identify any other residents who may be in need of dental services. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Social Services will audit Dental visits monthly to identify any residents who were scheduled for Dental services, but who missed the appointment to identify reasons and to track any repeat missed appointments. The results of the audit will be presented to monthly QA for further review and recommendations for 6 months or until QA determines no longer necessary. 5) When will the systemic changes be completed? By August 14, 2016.</p>		

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F 0311 SS=D Bldg. 00	<p>3.1-34(a)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review and interview, the facility failed to ensure a Restorative Nursing program was implemented for 1 of 3 residents reviewed for range of motion services of the 7 who met the criteria for range of motion services. (Resident #1)</p> <p>Finding includes:</p> <p>On 7/11/16 at 2:24 p.m., LPN (Licensed Practical Nurse) #1 indicated Resident #1 had contractures to his bilateral legs. The LPN indicated the resident did not have splints nor did he receive range of motion.</p> <p>On 7/14/16 at 10:10 a.m., the resident was observed to have contractures to both of his legs.</p>	F 0311	<p>F311 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident will be been reassessed by Therapy if eligible for a Restorative Program. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken. All residents who are not already on a Restorative Program will be audited for appropriate Restorative referral. And residents identified will be forwarded to Therapy for Restorative Program referral. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? When</p>	08/14/2016	

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	<p>The record for Resident #1 was reviewed on 7/12/16 at 1:58 p.m. The resident's diagnoses included, but were not limited to, quadriplegia, diabetes and pressure areas.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 5/24/16, indicated the resident had a functional limitation in range of motion to both sides of the upper and lower extremities. No active or passive range of motion was coded as being received.</p> <p>A Physical therapy evaluation and plan, dated 1/19/16, indicated the resident had impaired range of motion to both the right and left lower extremities.</p> <p>The plan of treatment indicated related to caregiver education for bilateral lower extremity passive range of motion to prevent further contractures so resident can continue to be able to sit in wheelchair with proper positioning.</p> <p>The long term therapy goal was to establish an effective Restorative Program to maintain the resident's current lower extremity range of motion.</p> <p>The 2/2/16 Physical Therapy discharge summary indicated staff were to continue</p>		<p>residents are discharged from Therapy, MDS/Restorative coordinator and Social Services will be involved in Discharge decision meetings. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? All Therapy Discharges for the month will be summarized and presented to QA monthly for review and further recommendations. This will be ongoing. 5) When will the systemic changes be completed? By August 14, 2016.</p>				

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	<p>range of motion for long term care and establish a Restorative Nursing Program.</p> <p>There was no documentation in resident's record related to a Restorative Nursing Program.</p> <p>Interview with Resident #1, on 7/15/16 at 10:55 a.m., indicated staff does not perform range of motion on his legs.</p> <p>Interview with the MDS Coordinator, on 7/15/16 at 11:00 a.m., indicated the resident was currently not on the Restorative Case Load. She indicated therapy did not refer him for Restorative when he was discharged.</p> <p>Interview with the MDS Coordinator, on 7/15/16 at 3:05 p.m., indicated she did not receive a therapy communication form at the time of discharge but she should have followed up with therapy to see if they recommended a Restorative Program.</p> <p>3.1-42(a)(2)</p>			

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure a dependent resident was provided toileting and incontinence care at least every two hours for 1 of 3 residents reviewed for activities of daily living of the 3 who met the criteria for activities of daily living. (Resident #34)</p> <p>Finding includes:</p> <p>Interview with Resident #34's Power of Attorney on 7/12/16 at 10:46 a.m., indicated that she did not think her sister received the help she needed with toileting.</p> <p>On 7/13/16 at 8:25 a.m., the resident was observed in the dining room getting her nails done.</p> <p>At 10:55 a.m., the resident remained in the dining room watching television.</p> <p>At 11:30 a.m., the resident was positioned at a table by the CNA (Certified Nursing Assistant) to have</p>	F 0312	<p>F312 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident has been provided toileting and/or incontinence care at least every 2 hours. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? An audit will be performed of all residents to identify which residents require toileting and/or checking for incontinence at least every 2 hours. The nursing staff will be educated on which residents have been identified and the residents will be checked at least every 2 hours. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Residents who require checking will be identified on the Care Plans and Help Sheets. Care Plans will be updated where needed to reflect a minimum of toileting and/or incontinence checks every 2</p>	08/14/2016

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	<p>lunch.</p> <p>At 11:35 a.m., the resident's niece entered the dining room to visit. At that time, the resident was removed from the dining room table to be checked for incontinence. The resident's brief was saturated with urine and soiled with dry stool. During the above times, the resident was not checked for incontinence by any staff member.</p> <p>The record for Resident #34 was reviewed on 7/12/16 at 2:54 p.m. The resident's diagnoses included, but were not limited to, non Alzheimer's dementia, altered mental status, hypothyroidism, systemic lupus, dysphagia, adult failure to thrive, muscle weakness, hypertension, seizures, arthritis and anxiety.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/23/16, indicated Resident #34 had a Brief Interview for Mental Status (BIMS) score of 5, indicating she was severely impaired for decision making and not alert and oriented. The resident was coded as having no behaviors. The resident needed extensive assist with one person physical assist for transfers, toileting, and personal hygiene. The resident was always incontinent of urine and bowel and was not on any toileting program.</p>		<p>hours. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? DON or designee will audit one of the identified residents on Day and Evening shift 5 days per week for 30 days. If compliance is achieved, the frequency of audits will be reduced to one resident per day of either Day or Evening shift for 5 days per week for the next 5 months. Results of the audits will be summarized and presented monthly to the QA committee for further recommendations. Audits will continue until the committee determines no longer necessary.</p> <p>5) When will the systemic changes be completed? By August 14, 2016.</p>		

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	<p>The current and updated 5/2016 plan of care, indicated the resident was always incontinent of bladder and required extensive assist with her toileting needs. The Nursing approaches were to provide incontinence care, toilet before and after meals, and at bedtime.</p> <p>Interview with the Director of Nursing (DON) on 7/13/16 at 11:50 a.m., indicated the residents should be checked every two hours for incontinence and if soiled, incontinence care should be performed.</p> <p>Interview with CNA #2 on 7/14/16 at 10:19 a.m., indicated the staff were supposed to check the residents every two hours and that was what she believed the facility policy was.</p> <p>Interview with the Director of Nursing on 7/14/16 at 1:01 p.m., indicated the facility had no policy regarding checking the resident every 2 hours for incontinence, it was just a standard of practice.</p> <p>3.1-38(a)(2)(C)</p>			

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F 0313 SS=D Bldg. 00	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to ensure assistive devices were provided to maintain a resident's hearing abilities for 1 of 1 residents reviewed for hearing. (Resident #10)</p> <p>Finding includes:</p> <p>Interview with Resident #10, on 7/11/16 at 1:58 p.m., indicated she has had trouble with her hearing aides and the Physician. She indicated the Audiologist told her she needed a hearing aide, however, nothing had been done about getting one, and she did not know what to do. Resident #10 indicated, "I will only be here for a couple more years and I want to enjoy it and be able to hear people when they talk without them</p>	F 0313	<p>F313 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Hearing aid will be ordered for resident by 8-14-16. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? An audit will be completed for all residents who have had hearing tested within the last year to assure follow up was completed for any recommendations made by the audiologist. Any residents identified as requiring any additional follow up to audiologist recommendations will be provided with such services. 3) What measures will be put into place or what systemic</p>	08/14/2016
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	<p>having to yell at me."</p> <p>The record for Resident #10 was reviewed on 7/14/16 at 2:01 p.m. The resident's diagnoses included, but were not limited to, shortness of breath, congestive heart failure, high blood pressure and pacemaker.</p> <p>The consent for audiology treatment was checked, however, there was no date or signature on the form.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/16, indicated Resident #10's Brief Interview for Mental Status (BIMS) was 15, indicating she was alert and oriented. The resident's hearing was adequate indicating no difficulty in normal conversation. The resident had no hearing aid.</p> <p>There was no current plan of care for hearing loss.</p> <p>An Audiology exam, dated 9/16/15, indicated the right ear had moderate to severe hearing loss. A right BTE (Behind The Ear) hearing aid was recommended by the Audiologist and an impression was taken at that time.</p> <p>The next visit by the Audiologist was, on 3/29/16, for complaints by the resident of</p>		<p>changes will be made to ensure that the deficient practice does not recur? Following each visit, a copy of the audiologist recommendations will be provided to both Social Services and to DON to assure follow up is completed within 72 hours of the audiology visit. Follow up progress will be discussed at each morning meeting until recommendations fulfilled. Social Services will be in-serviced by the Administrator regarding follow up on audiology recommendations in a timely manner. 4) How will the corrective action be monitored to ensure the deficient practice sill not recur,i.e. what quality assurance program will be put into place? Social Services will present monthly to the QA Committee a report of all Ancillary services provided for that month to include Audiology services rendered and timeliness of follow up of recommendations. The committee will review report and provide any additional recommendations for action. This will be for 6 months or until the committee determines these reports are no longer necessary. 5) When will the systemic changes be completed? By August 14, 2016.</p>		

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	<p>not being able to hear. The Audiologist removed an excessive amount of cerumen (ear wax) from both ears. The Audiologist indicated the resident was not due for an annual exam at that time. Another note by the Audiologist indicated "The patient was seen on 9/16/15, recommended to get right BTE hearing aid. Uncertain of that 9/16/15 recommendation. (Name) Social Service Director (SSD) called utilization review and left message. Per utilization review case was closed. Physician did not complete Medicaid section."</p> <p>The last visit by the Audiologist, dated 6/2/16, indicated "Checked right and left canal. Patient claimed the hearing aid does not help. The hearing aid is distorted, even if functional hearing aid could be too weak for degree of hearing loss." The right ear had moderate to severe hearing loss. The Audiologist recommended a right BTE hearing aid as originally recommended on 9/16/15.</p> <p>Interview with the SSD, on 7/14/16 at 3:00 p.m., indicated she was informed by the Audiologist the resident's Physician was completing the paper work incorrectly. She indicated she had not followed up with the Physician as to why the hearing aid had not been ordered. She further indicated she was going to</p>			

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	<p>call the Audiologist's office and have them fax over the information on why the hearing aid was never ordered.</p> <p>Interview with the SSD, on 7/15/16 at 8:25 a.m., indicated the audiologist faxed over the Medicaid medical clearance form that was completed by the resident's Physician. The Physician signed the clearance form on 9/27/15 and indicated the resident did not need hearing aides, therefore the case was closed. The SSD indicated she was unaware the Physician had declined the recommendation by the Audiologist and did not follow up with the Physician. The SSD indicated the resident started complaining she could not hear back in March 2016 out of her right ear, so the Audiologist came out again and ordered ear drops for the wax build up. The resident indicated at that time, that she would like a new hearing aide due to she was not able to hear out of the hearing aide she had at that time. The SSD indicated the resident had a hearing aid at that time, but still had complaints of not being able to hear. She indicated she had done nothing to get the resident a new hearing aid in March. The SSD indicated the Audiologist came back in June and re-recommended the hearing aid, however she had not followed up with the recommendation ensuring the resident received a new hearing aid.</p>			

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F 0315 SS=D Bldg. 00	<p>3.1-39(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's suprapubic catheter drainage bag was properly positioned below the resident's waist for 1 of 3 residents reviewed for urinary catheter use. (Resident #14)</p> <p>Finding includes:</p> <p>On 7/12/16 at 1:53 p.m., and 3:30 p.m., Resident #14 was observed in bed. At those times the resident's urinary drainage bag was observed hanging on the halo (an oval assist rail) by the resident's chest area and not below her waist.</p> <p>On 7/13/16 at 7:10 p.m., and 8:25 p.m.,</p>	F 0315	<p>F315 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The resident's urinary catheter drain bag has been positioned below waist and is no longer hanging on the bed halo. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? An audit will be performed of other residents with urinary catheter drain bags for proper placement. Any discovered out of place will be properly placed to hang below the waist and responsible staff member will be immediately re-educated. 3) What</p>	08/14/2016

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	<p>the resident was observed in bed. At those times the resident's urinary drainage bag was observed hanging on the halo (an oval assist rail) by the resident's chest area and not below her waist.</p> <p>The record for Resident #14 was reviewed on 7/12/16 at 2:09 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, neurogenic bladder, bladder stones, urinary retention, urethral tear and history of urinary tract infections.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, dated 6/23/16, indicated Resident #10 had a Brief Interview for Mental Status score of 12, indicating she had moderate impairment. The resident was totally dependent with one person physical assist for bed mobility, dressing, toilet use, and personal hygiene. The resident had an indwelling catheter with an active diagnosis of neurogenic bladder.</p> <p>The plan of care, updated 6/2016, indicated the resident had a suprapubic catheter and was at risk of developing a urinary tract infection related to neurogenic bladder. The Nursing approaches were to check for kinks and positioning each shift.</p>		<p>measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing Staff will be educated on proper positioning of Urinary Catheter Drain bags for residents. An audit of all residents with urinary catheter drain bags will be completed once per shift by the charge nurse daily for 30 days. Any incidents of non-compliance will be corrected immediately and the staff responsible will be identified and re-educated. The audits will be reviewed daily 5 days per week by the DON or designee for compliance. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The DON will provide a summary of the monthly audits for 6 months to the QA committee for further recommendations until the Committee determines audits are no longer necessary. 5) When will the systemic changes be completed? By August 14, 2016.</p>		

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F 0318 SS=D Bldg. 00	<p>Physician Orders, dated 5/26/16, indicated the resident had a suprapubic 18 FR (French) 5-10 cubic centimeters (cc) catheter.</p> <p>The current 9/2005 Catheter Care, Urinary, policy provided by the Director of Nursing on 7/14/16 at 2:30 p.m., indicated the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.</p> <p>Interview with the Director of Nursing, on 7/14/16 at 1:02 p.m., indicated the urinary drainage bag should have been positioned below the resident's waist and not on the halo assist rail.</p> <p>3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and</p>	F 0318	F318 1) What corrective action(s) will be accomplished	08/14/2016

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	<p>interview, the facility failed to ensure a resident with a limited range of motion received the necessary treatment and services related to the application of a splint for 1 of 3 residents reviewed for range of motion of the 7 residents who met the criteria for range of motion. (Resident #14)</p> <p>Finding includes:</p> <p>On 7/12/16 at 9:21 a.m., Resident #14 was observed with a contracture to her left arm and hand. At that time, there was no splint observed in her left hand.</p> <p>On 7/13/16 at 9:25 a.m., 7:10 p.m., and 8:25 p.m., the resident's left hand was closed in the shape of a fist. At those times, there was no splint noted in her left hand.</p> <p>On 7/14/16 at 5:02 a.m., and 8:15 a.m., the resident's left hand was closed in the shape of a fist. At those times, there was no splint noted in her left hand.</p> <p>On 7/14/16 at 8:15 a.m., two CNA's (Certified Nursing Assistants) were observed getting the resident up into her chair and providing morning care. CNA #2 indicated at that time, the resident did not have a splint in her left hand prior to morning care. The CNA looked in the</p>		<p>for those residents found to have been affected by the deficient practice? Resident#14 will consistently have splint in place as ordered. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? An audit will be performed on all residents who require splints to determine that an immediate replacement is available, and that their splints are being applied as ordered. Two sets of splints will be provided to allow for continued use of a splint while other is being cleaned. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will be educated on rotation of splints to allow proper cleaning and consistent ongoing availability of splint for resident, as well as necessity for assuring splints are applied to resident as ordered. Charge nurse will audit for proper placement of splints every shift and splints not in place when scheduled will be applied and responsible staff will be re-educated. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The DON/designee will review audits 5 days per week</p>	

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	<p>resident's dresser drawers and the hand splint was nowhere to be found. The resident indicated at the time, the splint was not applied to her hand last night.</p> <p>Interview with the MDS (Minimum Data Set) Coordinator, on 7/14/16 at 8:30 a.m., indicated she was the restorative nurse as well. She further indicated restorative therapy does not apply the splints to the residents. She indicated all the splints were applied by nursing staff at night time and removed in the morning. She also looked in the resident's room for the hand splint and was unable to find them.</p> <p>On 7/14/16 at 8:35 a.m., the MDS Coordinator entered the resident's room with two hand splints. She indicated both splints were in the laundry, however the laundry aid had no idea how long they had been there.</p> <p>Interview with Laundry Aide #1 on 7/14/16 at 12:00 p.m., indicated she had washed the resident's splints on Monday and placed them in a plastic bag and put them on the shelf in the laundry room.</p> <p>The record for Resident #14 was reviewed on 7/12/16 at 2:09 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, pain and debility.</p>		<p>for compliance and provide a summary monthly to the QA committee for review and further recommendation. The audits will continue for 6 months or until the QA committee determines is no longer necessary. 5) When will the systemic changes be completed? By August 14, 2016.</p>		

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	<p>The Significant Change Minimum Data Set (MDS) assessment dated 6/23/16, indicated the resident had a Brief Interview for Mental Status score of 12, indicating she had moderate impairment. The resident was totally dependent with one person physical assist for bed mobility, dressing, toilet use, and personal hygiene. The resident had range of motion impairments to both upper and lower extremities.</p> <p>The current and updated plan of care, dated 6/2016, indicated the resident had alteration in musculoskeletal status related to a contracture to the upper left extremity. The Nursing approaches were to perform passive range of motion before application of the splint and apply splint to left upper extremity, on at night time off in the morning.</p> <p>Physician orders on the 7/2016 Physician Order Statement, indicated to apply the splint to the left upper extremity at bed time, remove in the morning.</p> <p>A Quarterly Nursing assessment dated 6/23/16, indicated the resident had contractures to her upper and lower extremities.</p> <p>The restorative care plan and charting for</p>			

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F 0323 SS=D Bldg. 00	<p>the month of 7/2016, indicated passive range of motion was completed to the resident's left upper extremity 10 reps 3 to 7 times a week.</p> <p>The Treatment Administration Record (TAR) for the month of 7/2016, indicated there was no documentation the splint was donned and/or removed every night and morning.</p> <p>Interview with the Director of Nursing, on 7/14/16 at 1:45 p.m., indicated the resident should have had her splint applied at night by the CNA's and it was supposed to be removed in the morning.</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the residents were supervised while smoking and smoking supplies were appropriately secured when not in use for 2 of 3 residents who smoked at the facility. (Residents #44 and #47)</p>	F 0323	F323 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#44 no longer residesat the facility. Resident #47 has no smoking materials in her possession and all materials are kept in the Med	08/14/2016

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	<p>Findings include:</p> <p>1. On 7/11/16 at 11:08 a.m. until 4:00 p.m., there was an over bed table observed in the hallway outside of room 5 with 2 e-cigarettes noted laying on top of it.</p> <p>On 7/11/16 at 12:05 p.m., Resident #44 was observed being wheeled into the dining room and was seated at a table for lunch. The resident placed a pack of cigarettes and a cigarette lighter on the table during the meal. The cigarettes and the lighter remained there with the resident during the meal.</p> <p>Interview with alert and oriented Resident #10, on 7/11/16 at 1:58 p.m., indicated her tablemate had a pack cigarettes and a lighter on the table at lunch that day and she did not like it.</p> <p>On 7/12/16 at 9:30 a.m., Resident #44 was observed sitting outside in the patio area at a table. At that time, the resident was observed with her lighter and a pack of cigarettes next to her. The resident was not smoking at the time. There was a housekeeper sitting outside with the resident during her break. The housekeeper left after several minutes and the resident was left outside by</p>		<p>Room at the Nurses Station only to be provided by Staff or approved family member during any of the 3 designated Supervised smoking times in the designated area. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents will receive a Smoking Assessment to determine if they are smokers and aware of the facility smoking policy. Any residents identified as smokers will be given the smoking assessment to determine if safe to smoke and the residents and their responsible party will be provided with a copy of the Smoking Policy. Resident Smokers will be supervised either by staff or by designated family or visitor that has been educated to the facility smoking policy and approved by Administrator, Social Services or DON. All smoking materials including e-cigarettes, cigarettes and lighters will be collected following each smoking session and kept in the Med Room at the nurses station. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Smoking Policy will be provided to all new admits and to their responsible party if the resident does smoke. All smoking</p>				

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	<p>herself with the cigarettes and the lighter.</p> <p>On 7/12/16 at 9:50 a.m., Residents #44 and #47 were observed outside on the patio smoking. The Certified Occupational Therapist Aide (COTA) was sitting outside with them. After a couple of minutes the therapy aide left the area and the two residents remained outside smoking by themselves without staff supervision.</p> <p>Interview the COTA, on 7/12/16 at 10:00 a.m., indicated she was not supervising the residents while they were smoking, she was trying to convince one of them to attend therapy. She indicated neither resident was a flight risk and could be out there by themselves.</p> <p>On 7/12/16 at 10:30 a.m., there was a lighter observed on an over bed table in the hallway outside of Resident's #47's room. The resident's floor tile was being cleaned professionally and all of the resident's belongings were placed in the hallway.</p> <p>Interview with Resident #44, on 7/12/16 at 10:35 a.m., indicated she kept her cigarettes and lighter in her room unless her husband took them and brought them back to her. She further indicated she was able to smoke outside when she</p>		<p>materials will be surrendered to the nursing staff for safekeeping immediately upon admission to the facility. Staff will be educated to the Smoking Policy and to their responsibility to immediately report any violation of the facility smoking policy to the Administrator. Current families will be provided with a letter and the facility Smoking Policy. Summary of the Smoking Policy will be posted at all entrances to the facility. Smoking assessments will be updated a minimum of quarterly and with any significant change in resident status. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>Administrator/designee will interview staff and Smokers daily on various shifts for 6 months to determine if compliance has been maintained. Random audits of smoker's rooms will be performed by Administrator and SSD with their permission to determine if any smoking materials are present in resident personal belongings. Any smoking materials discovered will immediately be removed from resident's possession and family notified. Results of audits will be summarized and presented to QA. Results of Smoking Assessments will be summarized and presented to QA ongoing for</p>		

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	<p>wanted to and Nursing staff had not asked for her cigarettes or lighter after she was done smoking.</p> <p>Interview with the Administrator and the Director of Nursing (DON), on 7/12/16 at 10:55 a.m., indicated the definition of an independent smoker was a resident who could smoke at their leisure. She further indicated both Residents #44 and #47 were deemed independent smokers. She indicated the smoking materials were to be kept and locked up at the Nurses' station. The Administrator was unsure if the residents were keeping their smoking materials locked up at the Nurses' station. The Administrator and the DON were unaware Resident #44 had kept her cigarettes and lighter in her room at all times. The Administrator and the DON were then directed to the cigarette lighter on the over bed table in the hallway outside of Resident #47's room.</p> <p>Interview with the Social Service Designee (SSD) on 7/12/16 at 11:00 a.m., indicated she had thought all three residents (who were currently smoking) were given a copy of the current smoking policy.</p> <p>The current 1/1/16 Smoking Policy provided by the Administrator, on 7/12/16 at 11:30 a.m., indicated residents</p>		<p>recommendations. 5) When will the systemic changes be completed? By August 14, 2016.</p>				

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	<p>who pass the smoking assessment may smoke on the facility premises. The rules were residents who wish to smoke must clear a smoking assessment. Smoking materials must be kept at the Nurses' Station. Smoking is permitted outside the facility only, in the designated area.</p> <p>2. On 7/13/16 at 8:15 a.m., the Administrator provided an updated smoking policy. She indicated at that time, she was supposed to be using this policy and not the one provided yesterday. She indicated the facility was also using the wrong smoking assessments for each resident. The Administrator indicated new smoking assessments were completed for each resident and the new policy was given to each resident. She indicated the residents were to be supervised by facility staff at all times while smoking and she designated three times a day for the residents to smoke. She further indicated all smoking materials were to be kept at the Nurse's station. The Administrator indicated Resident #44 had refused to sign the consent to smoke and to agree to the new smoking rules.</p> <p>On 7/13/16 at 7:07 p.m., Resident #44 was observed outside on the patio with her husband smoking a cigarette. There was no staff present at that time.</p>			

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	<p>Interview with RN #1 at that time, indicated he did not know the current smoking policy and indicated he had thought a family member could be with the resident while they smoked. The RN was unaware the resident had refused to sign the consent to smoke earlier that day.</p> <p>Interview with the Administrator, on 7/14/16 at 10:45 a.m., indicated Resident #44 had finally signed the smoking consent form agreeing to the facility rules. If smoking is permitted in the building or on its premises, residents may smoke only in those areas which have been designated (this includes e-cigarettes). Each resident will be supervised by Facility staff, or a designated responsible family member or friend approved by the facility. All residents were prohibited from keeping any type of smoking materials (lighter, matches, cigarettes, etc.) in their rooms or on their person. If residents were permitted to smoke during their stay, facility staff will receive and safeguard all smoking materials.</p> <p>The new smoking policy provided by the Administrator, on 7/13/16 at 8:15 a.m., indicated all residents will be assessed for smoking safety upon admission</p>			

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	<p>3. The record for Resident #44 was reviewed on 7/15/16 at 9:45 a.m. The resident's diagnoses included, but were not limited to, cancer, heart failure, high blood pressure, diabetes, depression, asthma and syncope.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 6/8/16, indicated the Brief Interview for Mental Status was 15 indicating she was alert and oriented.</p> <p>The current plan of care, dated 6/9/16, indicated the resident was a smoker and does not require supervision to smoke. The Nursing approaches were to keep all materials at the Nurses' station and the resident will only smoke in designated areas.</p> <p>4. The record for Resident #47 was reviewed on 7/15/16 at 10:14 a.m. The resident's diagnoses included, but were not limited to, cancer of the esophagus, liver cancer, COPD (Chronic Obstructive Pulmonary Disease), high blood pressure, anxiety and depression.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 6/16/16, indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating the</p>			

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F 0329 SS=D Bldg. 00	<p>resident was alert and oriented.</p> <p>The current plan of care, dated 6/20/16, indicated the resident was a smoker and did not require supervision to smoke. The Nursing approaches were to keep all materials at the Nurses' station and the resident will only smoke in designated areas.</p> <p>Interview with Resident #47 on 7/15/16 at 11:00 a.m., indicated prior to Monday the resident was able to smoke anytime she wanted to. She further indicated, "I was supposed to give them my cigarettes and lighter, but I never did."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>			

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	<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 ensure there was an indication for the use and monitoring of an anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Residents #11)</p> <p>Finding includes:</p> <p>The record for Resident #11 was reviewed on 7/13/16 at 2:00 p.m. The resident's diagnoses included, but were not limited to, anxiety, major depressive disorder, and psychotic disorder with delusions.</p> <p>A Physician's order, dated 4/8/16, indicated the resident was to receive Xanax (an antianxiety medication) 0.25 milligrams (mg) twice a day as needed (prn) for anxiety.</p> <p>The resident received the prn Xanax on 5/7/16 at 8:00 a.m., 5/8/16 at 8:00 a.m.,</p>	F 0329	<p>F329 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#11 has expired. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? The MARs of all residents will be reviewed to determine what residents receive any PRN anti-anxiety medication. Residents identified will have documentation of interventions prior to the medication given. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing Staff will be educated by 8-14-16 on proper use and monitoring of PRN medication. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality</p>	08/14/2016

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F 0333 SS=D	<p>5/10/16 at 8:00 a.m., 5/16/16 at 1:50 a.m., and on 5/24/16 at 6:00 a.m.</p> <p>There was no documentation on the back of the Medication Administration Record (MAR) to indicate why the resident received the prn Xanax.</p> <p>The May 2016 Behavior intervention flow sheets indicated the resident had no behaviors on the above dates.</p> <p>There was also no documentation in the Nursing progress notes related to the resident having anxiety on the above dates.</p> <p>Interview with the Director of Nursing (DON), on 7/15/16 at 10:35 a.m., indicated a prn flow sheet should have been completed prior to giving the resident the prn Xanax. The DON indicated the resident had no prn flow sheets available for review.</p> <p>3.1-48(a)(6)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED</p>		<p>assurance program will be put into place? DON or designee will audit all residents who have PRN medications for proper documentation daily 5 times per week for 30 days then once per week for 6 months. Results will be summarized and presented to QA for recommendations. 5)</p> <p>When will the systemic changes be completed? By August 14, 2016.</p>	

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Bldg. 00	<p>ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure an anticoagulant (blood thinner) medication was given as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #28)</p> <p>Finding includes:</p> <p>The record for Resident #28 was reviewed on 7/13/16 at 2:07 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation (an irregular heartbeat), hypertension and dementia.</p> <p>A Physician's Order dated 5/2/16, indicated Coumadin (a blood thinner) 6 milligrams (mg), give 1 tablet by mouth daily.</p> <p>The May 2016 Medication Administration Record (MAR) indicated the following:</p> <p>-On 5/3/16 at 5:00 p.m., there was no documentation indicating the resident received his medication.</p> <p>-On 5/6/16 at 5:00 p.m., there was no documentation indicating the resident</p>	F 0333	<p>F333 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#28 has received his medication as ordered. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents receiving anticoagulants will have MAR audited to assure given as ordered. Any errors will be corrected appropriately. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? When DON/designee audits Physician orders for anti-coagulants, another nurse will be present to verify the order matches the MAR. Errors identified will be corrected immediately. This will be for 30 days, then weekly for 6 months. 4) How will the corrective action be monitored to ensure the deficient practice sill not recur, i.e. what quality assurance program will be put into place? DON/designee will audit MARs to assure Medications are given as ordered daily 5 times per week for 30 days. As long as compliance is</p>	08/14/2016			

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	<p>received his medication.</p> <p>-On 5/7/16 at 5:00 p.m., there was no documentation indicating the resident received his medication.</p> <p>A Physician's Order dated 5/9/16, indicated Coumadin 4 mg, give 1 tablet by mouth daily.</p> <p>The May 2016 MAR indicated the following:</p> <p>-On 5/15/16 at 5:00 p.m., there was no documentation indicating the resident received his medication.</p> <p>A Physician's Order dated 6/9/16 indicated, Coumadin 5 mg, give 1 tablet by mouth daily.</p> <p>The June 2016 MAR indicated the following:</p> <p>-On 6/20/16 at 5:00 p.m., there was no documentation indicating the resident received his medication.</p> <p>A Physician's Order dated 6/20/16 indicated, resume Coumadin 4 mg on 6/27/16.</p> <p>The June 2016 MAR indicated the following:</p>		<p>100%, audits will be reduced to 3 times per week for 6 months. Audit results will be summarized by DON/designee and presented to QA for further review and any recommendations. Reports will continue for 6 months or until the QA committee determines is no longer necessary. 5) When will the systemic changes be completed? By August 14, 2016.</p>		

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F 0356 SS=C Bldg. 00	<p>-On 6/23/16 at 5:00 p.m., there was no documentation indicating the resident received his medication.</p> <p>Interview with the Director of Nursing, on 7/15/16 at 11:30 a.m., indicated the above medication was not administered as ordered, the nursing staff should have followed the Physician's Orders.</p> <p>3.1-48(c)(2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data</p>			

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	<p>specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to post the Scheduled Nurse Staffing sign with the correct information related to the time frame for actual hours worked for 2 of 2 Halls of the 2 Halls in the facility. (The Front and Back Halls)</p> <p>Finding includes:</p> <p>On 7/11/16 at 9:00 a.m., 7/12/16 at 8:30 a.m., 7/13/16 at 8:30 a.m., 7/14/16 at 8:30 a.m., and 7/15/16 at 8:30 a.m., the Nurse Staffing sign indicated the incorrect information. The posted sign did not display the time frame for the actual hours worked for each shift.</p> <p>Interview with the Director of Nursing on 7/15/16 at 8:54 a.m., indicated she was not aware the time frame for the actual</p>	F 0356	<p>F356 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Scheduled Nurse Staffing hours now reflect the time frame for the actual hours worked. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The time frame for the actual hours worked has been placed on the Master form. 4) How will the corrective action be monitored to ensure the deficient practice sill not recur,i.e. what quality</p>	08/14/2016

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F 0363 SS=D Bldg. 00	<p>hours worked was to be indicated on the staffing sign.</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review and interview, the facility failed to follow two recipes for a therapeutic pureed diet. This had the potential to affect 1 of 1 residents in the facility who received a pureed diet.</p> <p>Finding includes:</p> <p>On 7/15/16 at 10:35 a.m., during the Scandinavian Vegetable Blend and Bread puree preparation, the following was observed:</p> <p>Cook #1 placed 1/2 cup of already cooked Scandinavian Vegetable Blend</p>	F 0363	<p>assurance program will be put into place? The Staffing form will be audited daily by the DON for compliance. Any non-compliance will be reported to the QA Committee monthly for 6 months or as determined necessary by the committee. 5) When will the systemic changes be completed? By August 14, 2016.</p> <p>F363 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Cook #1 has been re-educated and properly preparing pureed food. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? Residents receiving pureed food had the potential to be affected. The cook has received re-training on proper puree diet food preparation. 3) What measures will be put into place or what systemic changes will</p>	08/14/2016

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	<p>into a blender and then blended the mixture until it was a smooth. The Cook then added 1/2 cup of water to the mixture and blended it again. The Cook then added 1 scoop of Thick and Easy powder (a commercial thickener) to the mixture and blended again. She then scraped the mixture into a pan.</p> <p>Review of the pureed Scandinavian Vegetable Blend recipe, indicated to measure the desired number of servings into the food processor and blend until smooth. Add water if product needs thinning. Add commercial thickener if product needs to be thickened. The recipe did not indicate how much of the commercial thickener should be added.</p> <p>Continued observation indicated Cook #1 placed 1 dinner roll into a blender and added 1/2 cup of milk then blended the mixture until it was a smooth. The Cook then added 1 scoop of Thick and Easy powder to the mixture and blended again. She stopped the blender and added another scoop of the commercial thickener and blended one more time. She then scraped the mixture into a pan.</p> <p>Review of the pureed bread recipe, indicated to measure the desired number of servings into the food processor and blend until smooth. Add milk if product</p>		<p>be made to ensure that the deficient practice does not recur? All cooks will receive re-education on pureed food preparation. Pureed food will be audited for proper preparation 3 times per week and for different meals by the Dietary Manager. Any non-compliant preparation shall be identified immediately and the cook re-educated and/or disciplinary action will occur. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Dietary Manager will summarize audits and present report monthly to QA for 6 months for review and further recommendations until Committee determines no longer necessary to complete audits. 5) When will the systemic changes be completed? By August 14, 2016.</p>		

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F 0371 SS=E Bldg. 00	<p>needs thinning. Add commercial thickener if product needs to be thickened. The recipe did not indicate how much of the commercial thickener should be added.</p> <p>Interview with the Dietary Food Manager (DFM) on 7/15/16 at 11:20 a.m., indicated both pureed recipes did not specifically give an exact amount of the thickening agent that was to be used each time to make the food thicker. She indicated the cook should have added a little less water and/or milk at a time to determine if she even needed to add the commercial thickener.</p> <p>3.1-20(i)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to food that was opened and not dated and an accumulation of dirt, dust, and grease on the oven hood, griddle, refrigerator, and</p>	F 0371	<p>F371 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All foods identified have been discarded. All areas identified in the Kitchen and in the Dry Storage will be properly cleaned by 8-14-16.</p>	08/14/2016

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	<p>floors for 1 of 1 Kitchen. (The Main Kitchen)</p> <p>Finding includes:</p> <p>The following was observed during the Brief Kitchen Sanitation Tour on 7/11/16 at 9:10 a.m., with the Dietary Food Manager (DFM):</p> <p>a. There was a large amount of grease and dust in the oven hood. The lights in the hood were dusty as well.</p> <p>b. There were food crumbs and paper debris in the corner by the stove.</p> <p>c. There was a moderate amount of black sludge noted around the edges on the griddle.</p> <p>d. There was a large amount of food crumbs and paper products noted on the floor and in the corner on the floor behind the can rack.</p> <p>e. The bottom of the refrigerator was dusty and dirty.</p> <p>f. There was one package of white American cheese and 1 package of yellow American cheese that was opened and not dated. There was one large bag of parmesan cheese opened and not dated</p>		<p>2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents who eat have the potential to be affected. All food items will be properly stored in the Kitchen and in Dry Storage with date and label. All areas where food is prepared in the Kitchen will be cleaned and maintained.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff have been educated on proper Storage and Dating and Labeling. Staff have been educated to cleaning schedules and proper procedures for cleaning. Dietary Manager will audit cleaning schedule 5 times per week to assure completed satisfactorily. Dietary Manager will audit Kitchen and Dry Storage areas for proper dates and labels 5 times per week for proper compliance.</p> <p>4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Dietary Manager will summarize audit results and present to QA committee monthly for 6 months for review and any recommendations. This will be ongoing.</p>	

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	<p>and one bag of brown spoiled lettuce that was opened and not dated.</p> <p>g. There was one bag of summer blend frozen food opened and not dated in the freezer.</p> <p>Dry Food Storage Room.</p> <p>a. There were two bags of powdered sugar opened and not dated. One bag of macaroni noodles opened and not dated, 1 bag of rotini noodles opened and not dated, 1 bag of egg noodles opened and not dated, and 1 bag of spaghetti noodles opened and not dated.</p> <p>Interview with the DFM (Dietary Food Manager), on 7/11/16 at 9:30 a.m., indicated the food should have been labeled and dated after opening. The DFM indicated all of the above were in need of cleaning and/or repair.</p> <p>The current 2009 Date Marking policy provided by the DFM, on 7/15/16 at 11:30 a.m., indicated "When to date mark: A commercially prepared item is opened. When ready to eat food item is stored regardless of temperature and if an opened food item is not used within 24 hours."</p> <p>3.1-21(i)(2)</p>		<p>5) When will the systemic changes be completed? By August 14, 2016.</p>				

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F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread</p>			
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	<p>of infection.</p> <p>Based on observation and interview the facility failed to ensure the infection control practices and standards were maintained related to the improper storage of urinals and wash basins for 2 of 2 halls throughout the facility. (The Front and Back Halls)</p> <p>Findings include:</p> <p>1. The Front Hall</p> <p>a. On 7/14/16 at 1:20 p.m., Room 1 was observed. There was a urinal stored on top of a black milk crate. Two residents resided in this room.</p> <p>b. On 7/11/16 at 10:44 a.m., Room 8 was observed. There were two urinals stored on the floor underneath the head of the bed. On 7/12/16 at 8:48 a.m., there was a urinal stored on the back of the head board. Two residents resided in this room.</p> <p>2. Back Hall</p> <p>a. On 7/11/16 at 10:41 a.m., Room 9 was observed. There were multiple wash basins stacked on top of the other and stored in the resident's clothes closet. Two residents resided in this room.</p>	F 0441	<p>F441</p> <p>1) What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? Residentsand their roommates using urinals or wash basins have potential to be affected.</p> <p>2) How will otherresidents having the potential to be affected by the same deficient practice beidentified and what corrective action(s) will be taken? All residents' rooms will be audited todetermine which residents use urinals and/or wash basins. Any residentsidentified as using a urinal will be evaluated for proper use and preferencewhere to hang and preferences will be care planned. Wash basins will be contained in plastic bagfollowing use and replaced as needed.</p> <p>3) What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur? Staffwill be educatur on proper storage of urinals and wash basins by August 14,2016. Residents who request to storeurinals anywhere other than in the bathroom will have their preferences CarePlanned.</p> <p>4) How will thecorrective action be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be</p>	08/14/2016			

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F 0465 SS=E Bldg. 00	<p>b. On 7/11/16 at 10:31 a.m., Room 16 was observed. There was a wash basin stored on the floor next to the reclining chair. On 7/11/16 at 2:15 p.m., there was a urinal stored on the back of the headboard. Two residents resided in this room.</p> <p>c. On 7/12/16 at 8:46 a.m., Room 18 was observed. There were two wash basins stacked on top of the other and stored behind the bed. Two residents resided in this room.</p> <p>Interview with the Maintenance Director at the time, indicated the above items were improperly stored.</p> <p>3.1-18(b)(1)</p> <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. Based on observation and interview, the</p>	F 0465	<p>put into place? Administrator/designee will audit urinal placement and wash basins in bags compliance weekly and will summarize and present report to QA monthly for 6 months until QA committee determines no longer necessary.</p> <p>5) When will the systemic changes be completed? By August 14, 2016.</p>	08/14/2016	

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	<p>facility failed to ensure a functional and sanitary environment was maintained related to dirty and food splattered white PVC (polyvinyl chloride) pipes, a broken valve inside the three compartment sink and broken wall tile in the kitchen. Marred and gouged walls, loose/peeling cove bases, dried food substances on floors, peeling paint, and cracked and missing outlet plates for 2 of 2 halls and 1 of 1 kitchen areas. (The Front and Back Halls and the Main kitchen)</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Tour with the Dietary Food Manager (DFM) on 7/11/16 at 9:10 a.m., the following was observed:</p> <p>a. There was a build up of grease and dirt under the grease trap on the floor by the dish machine.</p> <p>b. The white PVC pipes underneath the dish machine were observed with a large accumulation of dirt and dried food spillage.</p> <p>c. The valve inside the three compartment sink was broken and rusted.</p> <p>d. The wall tile was cracked near the floor by the dry food storage rack.</p>		<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All identified areas have been cleaned and repaired.</p> <p>2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected. The identified areas in the Kitchen 1.a,b,c,d; the identified areas of the Front Hall 1.a,b,c,d; and the identified areas of the Back Hall 2. a-j will be cleaned and/or repaired by 8-14-2016. The cove bases that are peeling from the walls in the Dining Room will be repaired and the walls in the Dining Room will be cleaned and repaired.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Resident Rooms and Common Areas will be placed on a routine preventative maintenance program. Staff will be re-educated on procedure for identifying and documenting any areas in need of maintenance or repair in the Maintenance Log at the Nurses station. Administrator will review log weekly and sign off when completed.</p> <p>4) How will the corrective action be monitored to ensure the deficient</p>	

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	<p>Interview with the DFM (Dietary Food Manager), at that time, indicated all of the above was in need of cleaning and/or repair.</p> <p>2. During the Environmental Tour with the Administrator and the Maintenance Director on 7/15/16 at 1:40 p.m., the following was observed:</p> <p>1. Front Hall</p> <p>a. Room 1-a, the wall behind the reclining chair was marred and gouged. There was dried food and spillage on the wall next to the chair, and the base of the bedside table was dirty and had dried food spillage. Two residents resided in this room.</p> <p>b. Room 2-b, the wall behind the head of the bed was marred. Two residents resided in this room.</p> <p>c. Room 7-a, the cove bases were peeling and caving in around the walls. One resident resided in this room.</p> <p>d. Room 8-b, there was an accumulation of food crumbs on the floor next to the bed. Two residents resided in this room.</p> <p>2. Back Hall</p>		<p>practice will not recur, i.e. what quality assurance program will be put into place? Administrator or designee will audit Kitchen, Dining Room and all rooms once per month for proper cleanliness and maintenance. This will be ongoing. Results of audits will be summarized and presented to QA for further recommendations.</p> <p>5) When will the systemic changes be completed? By August 14, 2016.</p>		

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	<p>a. Room 9-b, the arm cushion on the resident's wheelchair was torn. The closet doors were marred at the base. Two residents resided in this room.</p> <p>b. Room 10-b, the maroon floor mat at the bedside was torn. The plastic behind the head of the bed was peeling and the white plastic on the wall was also peeling. 10-a, the arm cushion on the resident's wheelchair was cracked and peeling. Two residents resided in this room.</p> <p>c. Room 11-b, the box fan had an accumulation of dirt. The wall paint was chipped and marred. The white phone outlet was hanging from the wall and the wires were exposed. One resident resided in this room.</p> <p>d. Room 12-b, the ceiling plaster was peeling. The wall paint was chipped and marred. The floor was dirty and privacy curtain was stained. One resident resided in this room.</p> <p>e. Room 13-b, the wood around the air conditioning unit was loose. The wall paint was chipped and marred. The cove bases were peeling from the wall and the cable face plate was cracked. Two residents resided in this room.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2016
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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	<p>f. Room 14-b, the walls were marred. Two residents resided in this room.</p> <p>g. Room 15-a, the wall behind the bed was gouged. Two residents resided in this room.</p> <p>h. Room 16-b, the wall behind the reclining chair was marred. Two residents resided in this room.</p> <p>i. Room 17-a, there was coffee spillage underneath the resident's bed. The soffit behind the head of the bed was dirty and falling apart. The walls were scuffed and marred. One resident resided in this room.</p> <p>j. Room 18, there was a hole on the wall outside of the room. 18-b, the face plate for the phone outlet was missing. Two residents resided in this room.</p> <p>2. The Main Dining Room</p> <p>a. The cove bases were peeling from the wall. The walls were scuffed and marred.</p> <p>Interview at the time with the Maintenance Director indicated the above items were in need of cleaning and/or repair.</p>			

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F 9999 Bldg. 00	<p>3.1-19(f)</p> <p>3.1-14 PERSONNEL</p> <p>3.1-14(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>THIS STATE FINDING WAS NOT MET:</p> <p>Based on record review and interview, the facility failed to ensure six hours of dementia training was completed within six months of being hired for 3 of 8 employee files reviewed. (RN #3, CNA</p>	F 9999	<p>F9999</p> <p>1) What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? RN #3,CNA #3 and Maintenance Supervisor will complete the 6 hour Dementia Training by8-14-2016.</p> <p>2) How will otherresidents having the potential to be affected by the same deficient practice beidentified and what corrective action(s) will be taken? All current employee files will be reviewedfor completion of the 6 hour Dementia Training. Any employees discovered to require the training will receive by8-14-2016.</p> <p>3) What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur? 6hour Dementia Training is provided by the Administrator or designee with 3 hoursof the required 6 provided upon initial orientation and the final 3 are offeredmonthly to be completed within 6 months of hire. BOM/HR Director will</p>	08/14/2016	

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	<p>#3, and the Maintenance Manager)</p> <p>Finding includes:</p> <p>Employee files were reviewed on 7/15/16 at 11:00 a.m., the following employees were lacking six hours of dementia training.</p> <p>RN #3 (hired 9/30/15) - had one hour of dementia training completed.</p> <p>CNA #3 (hired 10/9/15) - had one hour of dementia training completed.</p> <p>Maintenance Supervisor (hired 12/14/15) - had no hours completed related to dementia training.</p> <p>Interview with the Business Office Manager on 7/15/16 at 1:36 p.m., indicated she could not find the additional hours of dementia training for RN #3 and CNA #3, nor could she find the initial 6 hours of dementia training for the Maintenance Supervisor.</p> <p>3.1-14(u)</p>		<p>monitor compliance by auditing monthly and notifying Employee, Department Manager and Administrator of status of pending sessions yet to complete.</p> <p>4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? BOM/HR will provide a summary of monthly status audits to the QA committee for review and further recommendations. This will be ongoing.</p> <p>5) When will the systemic changes be completed? By August 14, 2016.</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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