

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155381	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2015
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NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey, this visit included a State Residential Licensure Survey.</p> <p>Survey dates : December 29, 30 &amp; 31, 2014 and January 2, 5, 6, 7, &amp; 8, 2015.</p> <p>Facility number 000551 Provider number 155381 AIM number : 100267400</p> <p>Survey team: Michelle Hosteter, RN-TC Sandie Nolder RN Gloria Bond RN</p> <p>Census bed type: SNF: 19 SNF/NF: 91 Residential : 50 Total : 160</p> <p>Census payor type: Medicare : 21 Medicaid : 76 Other : 13 Total : 110</p> <p>Residential Sample : 7</p> <p>These deficiencies reflect state findings</p>	F 0000	<p>January 23, 2015</p> <p>Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on January 8, 2015. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health and Living and The Lodge credible allegation of compliance. We allege compliance on February 7, 2015. We are requesting a desk review for</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on January 15, 2015.</p>		<p>this plan of correction.</p> <p>If you have any further questions, please do not hesitate to contact me at 317-770-3401.</p> <p>Sincerely,</p> <p>Justin P. Vogt H.F.A Administrator</p> <p>Submission of this plan of correction in no way constitutes an admission by Harbour Manor Health and Living and The Lodge or its management company that the allegations contained in the</p>	

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F 0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF		<p>survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on January 8, 2015. Please accept this plan of correction as Harbour Manor Health and Living and The Lodge credible allegation of compliance by February 7,2015.</p> <p>This statement of deficiencies and plan of correction will be reviewed at the March Quality Assurance/Assessment Committee meeting.</p> <p>Response to Survey Ending January 8, 2015</p>		

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Bldg. 00	<p><b>EACH RES</b></p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide ongoing activities to keep residents mentally stimulated for 2 of 3 residents reviewed for activities. (Residents #91 and #131)</p> <p>Findings include:</p> <p>1. On 1/6/15 at 4:51 p.m., Resident #91's record was reviewed. Diagnoses included, but were not limited to, dementia without behavioral disturbances, ataxia, difficulty in walking, muscle weakness, lack of coordination, dysphagia, personal fall history, and spinal stenosis.</p> <p>The resident had a Care Plan dated 12/11/13, that addressed the problem she needed social and spiritual stimulation with her peers. The approaches included, but were not limited to, "12/11/13- -Activity staff will assist with transport to and from all activities [name of Resident] attends. Activity staff will inform of and invite [name of Resident] to all activities. Activity staff will make sure [name of</p>	F 0248	<p><b>Tag #248</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident 91 re-assessed and care plan reviewed and updated to meet the activity/stimulation needs of the resident</p> <p>Resident 131 assessed and care plan reviewed and updated to meet the activity/stimulation needs of the resident</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p>	02/07/2015

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	<p>Resident] has needed supplies for activities she attends. Activity staff will provide [name of Resident] a calendar of monthly activities."</p> <p>The resident's quarterly "Activity Assessment" dated 12/9/14, indicated while she was in the facility she felt it was very important for her to receive snacks between meals. While she was in the facility she felt it was very important for her to have books, newspapers and magazines to read and to be able to listen to music she liked. While in the facility she felt it was somewhat important for her to be around animals such as; pets. While she was in the facility she felt it was very important for her to do her favorite activities. While in the facility she felt it was somewhat important for her to go outside to get fresh air when the weather was good and somewhat important for her to participate in religious services or practices.</p> <p>On 12/30/2014 at 11:00 a.m., the resident was observed in the East lounge area leaning over in her wheelchair with her back bent over and her hands were touching her feet. She did not respond to verbal stimuli. The scheduled activity at this time was an outing to a department store.</p>		<p>All cognitively impaired residents, BIMS less than 10, have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>The activities calendar will be reviewed and updated to meet the activity needs of cognitively impaired residents, BIMS less than 10, to include sensory stimulation and one to one visits as appropriate.</p> <p>Activity staff will be re-inserviced on identifying and providing activities for the cognitively impaired.</p> <p><b>IV The facility will monitor the corrective action by</b></p>	

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	<p>On 12/30/2014 at 1:43 p.m., the resident was observed lying in bed with her eyes closed.</p> <p>On 12/31/2014 at 9:52 a.m., the resident was observed in bed sitting up at a 90 degree angle playing with her bed linens. The scheduled activity in the East lounge area was ball toss at 9:30 a.m.</p> <p>On 12/31/2014 at 1:26 p.m., the resident was observed sitting leaning over in her wheelchair in the East Lounge with the TV playing Family Feud. The resident was not watching TV. She was rubbing her legs. No activity was scheduled at this time.</p> <p>On 12/31/2014 at 3:03 p.m., the resident was observed sitting in her w/c in the East lounge. She was leaning over with her back bent rubbing her hands up and down her legs. The TV was playing, but the resident was not watching the TV. The scheduled activity was Bible study, which started at 2:30 p.m.</p> <p>On 1/2/15 at 11:00 a.m., the resident was observed lying in her bed on her left side with her eyes closed. A lunch outing was the scheduled activity at 11:00 a.m.</p> <p>On 1/2/15 at 2:13 p.m., the resident was observed lying in bed on her left side</p>		<p><b>implementing the following measures.</b></p> <p>Administrator/Designee will audit random sample of cognitively impaired residents will for activity offered and participation daily for 4 weeks, weekly x 4 weeks, monthly x 4 months.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is</p>				

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	<p>with her eyes closed.</p> <p>On 1/2/15 at 2:43 p.m., the resident was observed lying in bed on her left side. The scheduled activity was a special snack, which was a granola bar at 2:30 p.m.</p> <p>On 1/2/15 at 3:15 p.m., the resident was observed lying in bed on her left side rubbing the heating/air conditioning unit with her bed linens.</p> <p>On 1/2/15 at 3:39 p.m., the resident was observed lying in bed on her left side. She was awake lying in the bed. The scheduled activity was Game of life stories at 3:30 p.m.</p> <p>On 1/5/15 at 9:35 a.m., the resident was observed sitting in the East lounge area in her wheelchair with her head down and her eyes were closed. The TV was playing a news channel. The activity that was scheduled was walk and roll at 9:30 a.m., there was one other resident in the lounge with her and the other residents were taken to the activity.</p> <p>On 1/5/15 at 10:36 a.m., the resident was observed sitting bent over in her wheelchair in the East lounge area with her eyes closed. The TV was playing the Price is Right. Three other residents</p>		February 7, 2015		

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	<p>were sitting in the lounge with their heads down and their eyes closed and one resident was watching the TV. The scheduled activity was bingo at 10:30 a.m.</p> <p>On 1/5/15 at 11:15 a.m., the resident was observed sitting in her room next to her bed bent over with her eyes closed and her head down.</p> <p>On 1/6/15 at 6:30 p.m., the Administrator was observed going to the resident's room and obtaining her sensory blanket and giving it to her. She was observed using the sensory blanket.</p> <p>The activity calendar dated December 2014, indicated the resident attended the following activities: 12/29/14--3:30 p.m.--Sing Along as a passive participant. Hand massage and mail--did not indicate what participation level.</p> <p>12/30/14--6:30 p.m.--Game night as a passive participant. Volunteer visits and one on one visits--did not indicate what participation level.</p> <p>12/31/14--Snack time, reading, busying self in her room--did not indicate what participation level.</p>			

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	<p>The activity calendar dated January 2015, indicated the resident attended the following activities:</p> <p>1/1/15--9:30 a.m.--A to Z as a passive participant.</p> <p>4:30 p.m.--Music with Don as a passive participant.</p> <p>Family/friend visits--did not indicate what participation level.</p> <p>1/2/15--Hand massage-snack time and TV/radio--did not indicate what participation level.</p> <p>1/3/15--Busying self in room, one on one visits and mail--did not indicate what participation level.</p> <p>1/4/15--10:00 a.m.--Church as a passive participant</p> <p>2:30 p.m.-- Hymn singing as a passive participant</p> <p>Socializing with peers--did not indicate what participation level.</p> <p>1/5/15--one on one visits, snack time and family/friend visits--did not indicate what participation level.</p> <p>During an interview on 1/6/15 at 6:30 p.m., the Administrator indicated the resident had a sensory blanket that she was to have on her lap at all times when she was up, so that she would have</p>			

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	<p>something to keep her busy.</p> <p>2. On 1/6/15 at 5:07 p.m., Resident #131's record review was completed. Diagnoses included, but were not limited to, altered mental status, muscle weakness, dysphagia, lack of coordination, dementia without behavioral disturbance, depressive disorder, secondary parkinsonism, anxiety state.</p> <p>The resident had a Care Plan dated 2/12/14, that addressed the problem he could benefit from social and mental stimulation to enhance quality of life and maintain current cognitive status. The approaches included, but were not limited to, "9/30/14--Act Staff will introduce resident to those at activity and also see that he has needed supplies for activities attended. Act Staff will provide calendar of monthly activity and inform of and invite him to any activity he wishes to attend. Act Staff will transport resident to and from activity and ensure he has a good seat and that he can hear and see program to its fullest."</p> <p>The admit "Activity Assessment" dated 10/13/14, indicated the resident felt while in the facility it was somewhat important for him to have snacks available between meals. While in the facility he felt it was</p>			

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	<p>not very important to have books, newspapers and magazines to read. While in the facility he felt it was very important to listen to music that he liked. While in the facility he felt it was very important to be around animals such as; pets. While in the facility he felt it was somewhat important to keep up with the news. While in the facility he felt it was somewhat important to do things with groups of people. While in the facility he felt it was very important to do his favorite activities. While in the facility he felt it was somewhat important to go outside to get fresh air when the weather was good. While in the facility he felt it was somewhat important to participate in religious services or practices.</p> <p>12/30/14 at 9:52 a.m., the resident was observed lying in the bed with his eyes closed and did not respond to verbal stimuli. The scheduled activity was "Remember when" at 9:30 a.m.</p> <p>On 12/30/2014 at 1:29 p.m., the resident was observed sitting in the main hallway in his Broda chair and did not respond to verbal stimuli.</p> <p>On 12/31/2014 at 9:35 a.m., the resident was observed sitting with his eyes closed in his Broda chair in the East lounge area during a balloon toss activity with the TV</p>			

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	<p>playing with his eyes closed. The Activities Director was not observed to attempt to awaken the resident to attempt to engage him in the balloon toss activity.</p> <p>On 12/31/2014 at 9:41 a.m., LPN #17 and an unidentified CNA was observed transporting the resident to his room and placed him in bed while the balloon toss activity was still in progress.</p> <p>On 12/31/2014 at 1:28 p.m., the resident was observed sitting in his Broda chair with his eyes closed in the East lounge area with the TV playing Family Feud. There was no staff member observed in the lounge area.</p> <p>On 12/31/2014 at 3:04 p.m., the resident was observed sitting in his Broda chair with his eyes closed and was placed in front of the TV in the East lounge area. He did not respond to verbal stimuli. The TV was playing. There was no staff member observed in the lounge area. The scheduled activity was Bible study, which started at 2:30 p.m.</p> <p>On 1/2/15 at 2:10 p.m., the resident was observed being transported to the East lounge area in his Broda chair and placed in front of the TV, with a news channel playing. The resident was observed watching the TV, but there was no sound</p>			

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	<p>coming from the TV. No staff member was observed in the lounge area to engage him in an activity.</p> <p>On 01/02/2015 at 2:18 p.m., the Activities Assistant was observed asking another resident if she liked granola bars when Resident #131 asked the Activities Assistant if he could have something also. The Activities Assistant told Resident #131 he would come back and get him. The resident continued to watch TV with no sound coming from the TV.</p> <p>On 1/2/15 at 2:25 p.m., the Activities Director was observed transporting the female resident to the scheduled Granola activity that was starting at 2:30 p.m. Resident #131 was observed left sitting in front of the TV without the sound playing on the TV. No staff person was observed in the lounge area to engage him in an activity.</p> <p>On 1/2/15 at 2:51 p.m., the resident was observed sitting in his Broda chair in front of the TV without the sound playing. His eyes were closed. The Activities Assistant came back to the East lounge area and sat on the couch visiting with another resident sitting on the couch. When he finished visiting with that resident, he was observed transporting Resident #131, who had his</p>			

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	<p>eyes closed the whole time to the activity room and sat him at a table. The resident was observed sitting at the table with his eyes closed. He was not observed to have gotten a snack.</p> <p>On 1/2/15 at 3:00 p.m., the resident was observed sitting in the activities room with 4 other residents at a table with no staff in attendance and he had his eyes closed. No music was playing and no activity or snack was in front of him.</p> <p>On 1/2/15 at 3:14 p.m., the resident was observed in the activity room sitting in his Broda chair with his eyes closed. Soft rock music was playing. The resident was sitting at a table by himself with his eyes closed.</p> <p>On 1/2/15 at 3:19 p.m., the resident was observed being transported to the rehab lounge with his eyes closed for the next scheduled activity, which was Game of life stories activity at 3:30 p.m.</p> <p>On 1/2/15 at 4:15 p.m., the resident was observed sitting in his Broda chair with his eyes closed in the East lounge area. The TV was playing with no sound. There was no staff observed in the lounge to engage him in an activity.</p> <p>On 1/2/15 at 4:41 p.m., the resident was</p>			

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	<p>observed being moved from the East lounge area to the area in the hallway in front of the nurses station by CNA #6. His eyes were closed.</p> <p>On 1/5/15 at 9:35 a.m., the resident was observed sitting in his Broda chair with his head down and his eyes were closed in the East lounge area. The TV was playing a news channel. The activity scheduled at 9:30 a.m., was walk and roll. There was one other resident in the lounge with him and the other residents were taken to the activity.</p> <p>On 1/5/15 at 10:36 a.m., the resident was observed sitting in his Broda chair with his eyes closed in the East lounge area and the TV was playing Price is Right. Three other residents were sitting in the lounge with their heads down and their eyes closed and one resident was watching the TV. The scheduled activity was bingo at 10:30 a.m.</p> <p>On 1/5/15 at 11:26 a.m., the resident was observed sitting in his Broda chair with his eyes closed in the East lounge area with the TV playing.</p> <p>The activity calendar dated December 2014, indicated the resident attended the following activities: 12/29/14--3:30 p.m.--Sing Along-</p>			

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	<p>-passive participant. Hand massage and reading/writing letters--did not indicate the participation level</p> <p>12/30/14--2:15 p.m.--Game of Life Stories--passive participant. 6:30 p.m.- -Game Night--passive participant, TV/Radio--did not indicate the participation level.</p> <p>12/31/14--3:30 p.m.--New Year's Day Celebration--passive participant, one on one visits and mail--did not indicate the participation level.</p> <p>1/1/15--4:30 p.m.--Music with Don--passive participant, Snack time and family/friend visits--did not indicate the participation level.</p> <p>1/2/15--9:30 a.m.--Sit N' Stretch-passive participant, 2:30--Special snack Granola bar. Hand massage--did not indicated the participation level.</p> <p>1/3/15--9:30 a.m.--Memory Lane-passive participant. Family/friend visit and busying self in room--did not indicate the participation level.</p> <p>1/4/15--10:00 a.m.--Church--passive participation, 2:30 p.m.--Hymn singing--passive participation, TV/Radio--did not indicate the participation level.</p>			

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	<p>1/5/14--Hand massage, family/friend visits and one on one visits-did not indicate the participation level.</p> <p>During an interview on 1/6/15 at 11:45 a.m., the Activities Director indicated that if a resident was in an activity and had his or her eyes closed, the participation code for that activity would be no activity participation. She indicated if the resident was awake or in the activity for at least 15 minutes she was told she could count that time as the resident being in the activity. She indicated the person who does the highlighting was the Activities Assistant. He highlights each persons calendar for the month to indicate the level of participation. She indicated yellow was active, pink was passive, blue was refused and green was not able to participate.</p> <p>The Activities Director indicated Resident #131 did not get offered to participate in the balloon toss on 1/2/15. She indicated his January 2015 calendar indicated he was a passive participant on 1/2/14 at the Granola snack time at 2:30 p.m., but he did not receive a snack because he was on a pureed diet. She indicated residents on mechanically altered diets and/or those who were</p>			

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	<p>unable to feed themselves did not usually get a snack because of their diets. She indicated the activity staff were not allowed to feed residents. The Administrator indicated that LPN #5 would be starting to make a list of the people on mechanically altered diets, then a CNA would go to the activity and feed the residents that needed assistance with eating the snack at snack time.</p> <p>During an interview on 1/7/15 at 2:40 p.m., the Activities Director indicated that the one on one activity was an activity that could be done anywhere in the facility with the residents. The room in activity was completed in the resident's room. She indicated the one on one activities that were usually done were storytime, smelling oils, sensory touch with different types of fabric, balloon volleyball and pushing the residents around the facility in their chairs. She indicated Resident #91's one on one activities consisted of a sensory blanket that she was given or she liked to play balloon volley ball.</p> <p>The Activities Director indicated the friends/family visits were when the residents had visits from family or friends. She indicated the hand massage was done with scented lotions unless the resident was unable to use them. She</p>			

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F 0309 SS=D Bldg. 00	<p>indicated they massage the residents hands and worked their way up to the elbows. She indicated exercise/therapy activity was when a compact disc was played that told the residents what movements to do for exercise. She indicated for Residents #91 and #131, the activity staff helped them move their extremities.</p> <p>3.1-33(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to use proper infection control techniques while performing wound care for 1 of 2 residents reviewed for wounds ( Resident #110) and to look for a root cause of behaviors for resident with dementia for 1 of 5 reviewed for unnecessary medications. (Resident #97)</p> <p>Findings included:</p> <p>1. The record review for Resident # 110 was completed 01/05/2015 9:18 AM.</p>	F 0309	<p><b>Tag #309</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #110 was assessed 1/5/15, 1/13/15, and 1/19 for infection with no signs and</p>	02/07/2015			

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	<p>Diagnoses included, but were not limited to, dementia, chronic pain, post left hip surgery, stage 3 wound to left hip.</p> <p>The notes from the wound clinic dated 11/21/14 indicated the resident had been resistant to healing despite numerous interventions,. The plan was to examine any underlying characteristics that may impede healing. The wound was caused by hardware, believed to be associated with hardware, however patient family wanted palliative care for wound at that time.</p> <p>A physician's order dated 12/3/14 indicated to pack wound to left hip with iodoform packing cover with foam and secure with tape.</p> <p>An observation of wound care on 01/05/2015 10:00 a.m., LPN #9 indicated he was the wound nurse. The wound nurse gathered his wound care supplies of normal saline to cleanse the wound, 4 x 4 gauze to clean wound, Silver Nitrate (an antiseptic cleaner for wound), a foam dressing and clear adhesive to keep the wound dressing in place.</p> <p>Then LPN #9 placed all the wound supplies onto the resident's bedside table without placing a barrier between the table and the wound care supplies. He</p>		<p>symptoms of the wound noted. LPN#9 did not provide treatment to the wound on 1/5/14. Resident #110 medical record reviewed and Registered Nurse that applied the treatment was provided skills validation on 1/5/14.</p> <p>Resident #97 care plan reviewed and 11/21/14 residents behavior of yelling identified and interventions included assist to toilet, offering food/drink, assess for constipation, and assist to bed. Care plan updated to reflect the root cause of her yelling r/t basic needs being met.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents with treatment dressings have the potential to be affected by the alleged deficient practice.</p>				

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	<p>then sanitized his hands with foam sanitizer, and pulled a pair of gloves out of his uniform pant leg pocket and donned the gloves.</p> <p>LPN #9 took the old dressing off. The old dressing was a tegaderm dressing and the iodoform packing tape was stuck to the tegaderm dressing and had moderate serosanguinous drainage on it. There was no foam dressing in place at that time. He threw the old dressing into the garbage. Without washing his hands or sanitizing, he donned a pair of gloves he retrieved from his pants pocket.</p> <p>LPN #9 then poured normal saline on a 4 x 4 gauze and wiped with the 4 x 4, in a circular motion around the base of wound, turned the edge of the 4 x 4 over, and wiped 2 more times in a circle in the area he had already cleaned. He measured the outside of the wound to be 0.5 centimeters x 0.5 centimeters. He indicated the undermining measurements were left to the wound clinic.</p> <p>The LPN #9 then took the silver nitrate Q- tip and rubbed it around the inside of the wound. He then took the Iodoform packing and pulled a pair of scissors out of the breast pocket of his uniform, cut the iodoform and then used the end of the Q- tip to pack the iodoform into the</p>		<p>Residents with behaviors have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Licensed nurses will be re-educated using a skills validation tool for wound care.</p> <p>Social services will include root cause of behavior in the care plan process upon admission, quarterly, or with new or worsening behaviors.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p>	

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	<p>wound. He then placed the Biotin foam dressing over the wound, placed a clear dressing over the wound and dated the dressing. At 10:15 a.m. he washed his hands for 20 seconds.</p> <p>1/5/2015 10:24 a.m., during interview, LPN #9 indicated no knowledge of a need for handwashing before the donning of his gloves at the start of the dressing change, or in between soiled dressings and preparing to put the new dressing on. He also had no knowledge of the fact that his gloves and scissors in his pockets were a concern. The Administrator was present during the interview.</p> <p>On 1/5/15 at 10:45 a.m., the DON provided a blank undated skills validation checklist for wound care and the document indicated, "...8. Put equipment supplies on overbed table on clean field (use clean towel, paper towel, pillow case) 9. Wash hands, put on gloves...14. remove soiled dressing 15. Put soiled dressing in plastic bag near end of bed. 16. Remove gloves, use hand sanitizer. 17. Open dressings and other products using clean technique...20. Cleanse wound, clean from least contaminated area to most contaminated (usually, from center of wound out) 21. If touching wound, remove gloves, use hand sanitizer 22. put on gloves...."</p>		<p>SDC/Designee will audit random direct wound care observations utilizing the skills validation tool weekly times 4 weeks, monthly times 4 months.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>The interdisciplinary team will utilize the Medication Management Minutes log to monitor residents for new or worsening behaviors of new admissions and current residents weekly x 4 weeks, monthly x 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>	

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	<p>On 1/5/2015 10:48 a.m., the DON indicated the LPN #9 should have used clean gauze when cleaning the wound, not the folded gauze, after wiping the first time with normal saline. She also indicated the scissors should be cleaned before used.</p> <p>2. On 1/07/2015 12:19 p.m., the record for Resident #97 was reviewed. Diagnoses, included, but were not limited to, Dementia, depression, heart failure, renal failure, diabetes, constipation and renal failure.</p> <p>On 01/02/2015 4:20 p.m., the resident was observed calling out "I need help." LPN #4 was observed sitting at the nurses desk. There were two aids and a nurse at the nurses station and LPN #9 was walking up from the East 1 hallway. The LPN #9 asked LPN #4 who was yelling and she indicated "probably (name of Resident #97) as she does that sometimes." The resident was observed yelling " I need help" again and LPN #9 started toward the resident room at that time. LPN #4 who remained at the desk, indicated she probably needed a drink of water. LPN #4 then got up and went to the resident and asked what she needed, the resident indicated she needed to go to the bathroom.</p>		<p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is February 7, 2015</p>	

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	<p>The physician's order dated 4/10/14 was to increase Risperdal (an antipsychotic) 0.5 milligrams from 0.25 milligrams daily.</p> <p>There was documentation in physician progress notes dated 4/10/14 which indicated the use of Risperdal was for delusions and hallucinations.</p> <p>The nursing progress notes were reviewed and indicated: "...3/2/14 at 1:39 a.m. resident was yelling out...</p> <p>3/13/14 at 1:07 a.m. the resident was yelling out off and on for help...</p> <p>3/23/14: Resident has yelled out 'help me' multiple times. has had two episodes of yelling out 'help me' to go to the restroom...</p> <p>3/24/14: 3:09 a.m. resident resting comfortably in bed, had two episodes of yelling out 'help me' to go to the restroom. 11:58 a.m. resident remains anxious and agitated and yelling out most of the morning to be put in bed and taken out of bed...</p> <p>3/28/14 : 12:47 p.m. new orders received from pharmacy recommendation.</p>			

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	<p>Discontinue Risperdal 0.5 milligrams and start Risperdal 0.25 milligrams at night...</p> <p>4/4/14 at 1:18 a.m. yelling out help me help me. Staff assisted resident with toileting and back to bed. At 1:30 a.m. in room yelling out at that time stating come help me, you will never help me. The nurse was at the beside with the resident and she stated she was uncomfortable and couldn't sleep. The nurse assisted the resident with repositioning and offered her food and fluids but all were unsuccessful. The resident continued yelling out. Nurse provided resident with medication at that time for pain...</p> <p>4/7/14 2:07 a.m. resident yelling out most of shift, needs/wants met each time, will continue to monitor...</p> <p>4/15/14 : 3:03 a.m. resident yelling out multiple times this shift, resident's needs/wants each time. will continue to monitor...</p> <p>4/18/14 : 2:31 a.m. Staff entered room to resident yelling out 'come here, help me, come on' Staff toileted resident and was going to assist her back into bed and she stated she did not want to lay down she was hungry and thirsty. Staff assisted resident into lounge and provided food</p>			

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	<p>and fluids at this time Resident yelling out multiple times...</p> <p>5/6/14 : 1:26 p.m. Resident yelling out 'I wanna go to bed' several times after breakfast and ' I need help' several times this shift to be taken to the bathroom...</p> <p>6/2/14 : resident had 3 episodes of yelling during the night. she was yelling 'help me' staff toileted resident, offered her fluid and drink, resident rested comfortably in bed...</p> <p>6/13/14: 6:14 a.m. resident yelling out while in bed, "I want something to eat." ...</p> <p>8/18/14 : 7:42 a.m. resident yelling loudly, "help me" several times this morning while sitting in the lounge area. The Social Services staff talked to the resident and she told her she was having pain in her legs and asked for a dink. The Social Services staff got her some orange juice and asked nursing about medication for pain. The nursing staff indicated the resident had been given Tylenol for her pain. 5:00 p.m. Resident yelling continuously to be placed in bed, when placed in bed , then will yell continuously to get up in her wheelchair...</p> <p>11/17/14 : 1:39 a.m. resident yelling</p>			

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	<p>continuously from bed. Taken by nurse out of bed to sit in lounge. The resident continued to yell while in lounge. Attempted to take resident to the bathroom, resident then stated she wanted to go back to bed. Put resident in bed and she complained of lower leg pain. Given pain medication...</p> <p>12/21/14 3:02 a.m. indicated the resident was trying to get out of bed, talking to family that was not there and wanting to cook. The physician ordered an antibiotic for the resident on 12/23/14 for a urinary tract infection...</p> <p>1/4/15 5:39 a.m. The resident had been restless that night and yelling out to get up. Resident put into chair but continued to yell out. Resident then asked to lay her on the floor. Staff talked with her with no result. Pain medication given with no results. Resident returned to bed. She had 2 bowel movement that shift....."</p> <p>The behavior documentation for April 2014 through January 2015 indicated frequent episodes of yelling on various shifts on various dates.</p> <p>The review of all nursing progress notes, social service notes, behavior documentation and physician progress notes indicated no discussion regarding</p>			

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F 0312 SS=D Bldg. 00	<p>these behaviors and to establish a root cause for her yelling out.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, a resident was not provided hygiene care for her nails for 1 of 2 residents reviewed for activities of daily living. (Resident #34)</p> <p>Findings included:</p> <p>On 1/2/2015 at 11:08 a.m., the record review for Resident # 34 was completed. Diagnoses, included but were not limited to, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Alzheimer's disease, monoarthritis, macular degeneration, and depression.</p> <p>On 1/2/2015 11:49 a.m., the resident was observed to have long nails and on the right hand, the 1st and 2nd digits were observed to have dark matter underneath the nail bed.</p>	F 0312	<p><b>Tag #312</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #34 had nail care provided 1/2/15.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the</b></p>	02/07/2015

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	<p>The documentation for showers and other hygiene care for November 2014 indicated the resident received a shower or a complete bed bath on 11/3/14, 11/7/14, 11/10/14, 11/14/14, 11/21/14, 12/1/14, 12/8/14, 12/11/14, 12/15/14, 12/19/14,12/25/14 and 12/29/14. There was areas on the form for the aids to check off a box indicating nail care was done. There was no documentation of nail care being done.</p> <p>On 1/07/15 at 9:49 a.m., the Director of Nursing indicated the nails should be clipped when they are over the tips of the fingers. If a female wanted them long, the aids needed to clean them out if they have any noticeable debris.</p> <p>3.1-38(3)(E)</p>		<p><b>deficient practice.</b></p> <p>All residents have the potential to be affected by the alleged deficient practice</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Nursing staff to be re-educated on providing and documenting nail care.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON/Designee will audit residents randomly utilizing an audit tool daily times 4 weeks, weekly times 4 weeks, monthly times 4 months. Results of this audit will be reviewed at the monthly Quality Assurance</p>	

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F 0325 SS=G Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to ensure weight loss prevention interventions were	F 0325	Committee meeting and frequency and duration of reviews will be adjusted as needed.  Facility Administrator will be responsible for ensuring compliance.  <b>V. Plan of Correction completion date.</b>  Plan of Completion date is February 7, 2015	02/07/2015

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	<p>provided to prevent a resident from experiencing a 11.2% significant weight loss. This impacted 1 of 4 residents reviewed for nutrition and weight loss. (Resident #85)</p> <p>Findings include:</p> <p>On 1/5/15 at 3:37 p.m., Resident #85's record was reviewed. Diagnoses included, but were not limited to, lack of coordination, vascular dementia with delusions, constipation, altered mental status, hyperlipidemia, depressive disorder, hypothyroidism, vitamin B deficiency and chronic anemia disease.</p> <p>On 1/5/15 at 8:48 a.m., the resident ate 50% of her breakfast and drank 120 ml (milliliters) of her orange juice. She was served biscuits and gravy on a plate and cream of wheat cereal was served in a bowl. She was eating her breakfast in her room and no staff member was observed in the room to assist her eat her breakfast.</p> <p>On 1/5/15 at 6:01 p.m., the resident received a cheeseburger on a plate, three bean salad in a small bowl and vanilla ice cream in a bowl. She received a glass of chocolate milk and cranberry juice to drink for dinner. An unidentified CNA came into her room to assist her with her meal and she accepted the assistance.</p>		<p><b>Tag #325</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #85's weight on 1/4/15 is 116.2 pounds with a BMI of 18.8 and increase of 3 pounds from the weight of 113 on 12/31/14. Resident care plan and meal ticket reviewed and include all meal time interventions. Resident care plan updated for meal assistance and location preferences.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic</b></p>	

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	<p>On 1/6/15 at 1:25 p.m., the resident had candied sweet potatoes in a bowl, steamed cabbage in a bowl, herbed pork loin sandwich on a plate and a piece of homemade iced chocolate cake on a plate. She was being assisted to eat by LPN #5. She had a chocolate magic cup to eat, 2 chocolate mighty shakes, she drank a 12 oz glass of chocolate milk and she had an 8 oz glass of lemonade. She was eating in the main dining room at a regular table, not an assist table.</p> <p>The resident's current nutrition Physician orders dated January 2015, included , but were not limited to the following orders. 12/11/14--Regular diet with supercereal at breakfast, chocolate milk, fortified pudding-double portion for lunch and dinner. Sandwiches at all meals. Special Instructions: Food in bowls.</p> <p>No consumption's could be found documented for fortified pudding-double portion for lunch and dinner, which the physician had ordered on 12/11/14. The fortified pudding-double portion was not observed being served to the resident on 1/5/15 at 6:01 p.m., with her dinner meal or 1/6/15 at 1:25 p.m., with her lunch meal. The fortified pudding-double portion was not found documented on the resident's lunch meal ticket for one of the</p>		<p><b>changes to ensure that the deficient practice does not recur.</b></p> <p>Dietary staff, nursing staff, and managers on dining duty to be re-educated regarding review of all meal ticket for therapeutic interventions prior to meal delivery.</p> <p>Resident's meal tickets reviewed and verified for current therapeutic dietary interventions.</p> <p>Nursing staff to be re-educated on following plan of care including level of assistance, location, and meal preferences.</p> <p>Residents plan of care and nursing assignment sheets reviewed for level of assistance and location for meals</p> <p>Meal tickets to be monitored each meal prior to delivery to resident.</p>	

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	<p>items to be served to her on 1/6/15 at lunch.</p> <p>The resident's weight for the last 180 days were as follows:</p> <p>07/04/14-130 08/04/14-127 08/12/14-127 08/19/14-125 09/04/14-122 10/03/14-123 11/05/14-119 11/13/14-117 11/18/14-118 11/20/14-122 11/25/14-119 12/04/14-112 12/09/14-115 12/15/14-117 12/24/14-117 12/31/14-113 01/04/14-116</p> <p>The resident's quarterly MDS (Minimum Data assessment) dated 11/25/14, indicated the resident's ability to see in adequate light was moderately impaired and she did not have corrective lenses. She required limited assist with one person physical assist for eating.</p> <p>The IDT (Interdisciplinary team) Clinically at Risk Review dated 1/1/15, indicated Resident #85 had a 12% weight</p>		<p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DM/Designee will audit residents dietary interventions utilizing an audit tool daily at random meals times 4 weeks, weekly times 4 weeks, and monthly x 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p><b>V. Plan of Correction completion date.</b></p>				

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	<p>loss in 158 days. She had a previous weight of 117 and her current weight was 113. The current intervention was to move the resident to an assist table to encourage more consumption in an attempt to stabilize her weight loss.</p> <p>The resident's annual "Nutrition-Nutritional Assessment Comprehensive" dated 1/6/15, indicated the resident's diet was a regular diet with supercereal at breakfast. She ate in the main dining room. She weighed 116 pounds and her usual body weight range was 117-143 pounds. Her Body Mass Index (BMI) was 18.8. The resident's average PO (by mouth) intake at meals was 50%. Her weight status indicated she had a &lt;7.5% weight change in 90 days and her BMI was &lt;18.5 or &gt;24.9. Her Oral/Nutritional food intake meets 26-75% of her estimated needs.</p> <p>A Registered Dietician progress note dated 12/22/14, indicated "Resident with noted 11.2% weight loss x 184 days. Weights past month have ranged from 112-117 lb. Current BMI is lower for age but WNL [within normal limits] at 18.7. Diet remains regular with intakes averaged at 50-75%. Nutrition interventions in place for weight maintenance include fortified cereal, chocolate milk with meals, double</p>		Plan of Completion date is February 7, 2015	

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	<p>portion of fortified pudding with lunch and dinner, sandwich with all meals. Suggest continuing current nutrition interventions."</p> <p>The resident had a Care Plan dated 11/28/14, that addressed the problem she would refuse to consume meals at times. The approaches included, but were not limited to, "12/1/14--Asist [sic] resident with feeding if she will allow. Food to be served in bowls to make self feeding easier [sic]. Offer alternate foods when resident resists eating. Provide snacks/supplements when &lt;50% is consumed."</p> <p>The resident had a Care Plan dated 11/7/14, that addressed the problem she was at risk for weight loss due to a history of weight loss, poor po (oral) intake, refused meals at times and diagnosis of dementia. The approaches included, but were not limited to, "1/2/15--resident to sit at assist table for additional monitoring and encouragement... 12/29/14--serve diet as ordered: Regular. Supercereal at breakfast, chocolate milk, Fortified pudding-double portion for lunch and dinner. Sandwiches at all meals. 12/18/14--provide sandwich or finger foods for lunch and dinner. 11/26/14--Magic cup for lunch and dinner.</p>			

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	<p>11/7/14--add chocolate milk at meals. monitor weights weekly. provide supplements as ordered [sic]. rd to eval. snacks between meals."</p> <p>The resident had a Care Plan dated 4/15/14, that addressed the problem she required a regular nas (no added salt) diet and she had the potential for weight loss due to difficulty adjusting. The approaches included, but were not limited to, "...4/24/14--Resident will be move to another table in dining room closer to feed table for encouragement. 4/15/14--Explain to resident risks versus benefits of following dietary regimen/restrictions. Provide the resident with as much control as possible in routines, food preferences, etc."</p> <p>The resident's meal intakes were reviewed from 7/1/14 to 1/5/15 and she averaged these intakes for the following meals: Breakfast-50-75% Lunch-50-75% Dinner-50-75%</p> <p>During an interview on 1/5/15 at 8:48 a.m., the resident indicated the food she received that morning (biscuits and gravy and cream of wheat) was "not fit to feed a dog and that is why I am losing weight."</p>			

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	<p>During an interview on 1/5/15 at 9:10 a.m., LPN #4 indicated the resident was to have a sandwich with every meal.</p> <p>During an interview on 1/5/15 at 6:01 p.m., the resident indicated she did not like the cereal the facility feeds her every morning.</p> <p>During an interview on 1/7/15 at 9:30 a.m., the Administrator indicated the resident refused to eat in the assist dining room. The DON indicated there was no documentation on the Care Plan or progress notes to indicate the resident had refused to eat in the assist dining room.</p> <p>During an interview on 1/8/15 at 9:40 a.m., the Director of Nursing (DON), Registered Dietician (RD), Administrator and Director of Dining Services (DDS) were in attendance. The DON indicated there were no alternatives offered when residents did not eat a certain percentage of food and there was no place to document when an alternative was offered to residents in place of the regular meal. She indicated she had expected the staff to offer an alternative meal to residents when they noticed residents were not eating their meals. She indicated the alternative and regular meal was both totaled into the meal intake together. The RD indicated at that time</p>			

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	<p>she was notified about weights by a referral sheet that was given to her, the Assistant Director of Nursing emailed every week with the following information weight losses, current interventions, significant weight losses to review and a weight variance report to review. She indicated this resident's weight loss interventions that were currently in place were feeding assistance, Med pass 120 ml (milliliters) three times daily, fortified pudding-double portions at lunch and dinner, sandwiches with every meal and her food was to be placed in bowls. The DDS indicated at that time any fortified foods, which would be listed on the resident's meal ticket would have a diamond next to the fortified food on the meal ticket. She indicated the meal ticket should print out every meal with the fortified foods listed on the resident's meal ticket.</p> <p>A current policy titled "Nutrition &amp; Hydration At Risk Program" undated, was provided by the DON on 1/8/15 at 3:49 p.m., indicated "Residents at nutrition and/or hydration risk will be identified through the interdisciplinary process. Residents who are found to be at risk are placed on a Nutritional/Hydration Risk Program. Residents are reviewed through the</p>			

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	<p>Interdisciplinary Nutrition at Risk (NAR) meeting bi-monthly... Residents who develop conditions/needs as listed below may be placed in the nutrition/hydration at risk monitoring program: Residents with weight loss of 5% in one month and 10% in 6 months which was not desired or expected, Residents with a pressure ulcer or other significant skin conditions, Residents with a diagnosis of malnutrition, dehydration, or dysphagia, Residents receiving enteral feedings or TPN... The RD is responsible for recommending nutritional interventions... Food intake will be recorded on all residents in percentages; this will include any meal replacement, documentation of fluid intake in cc amounts, and documentation of any physician ordered supplements...."</p> <p>A current policy titled "Nutritional and Weight Monitoring" undated, was provided by the DON on 1/8/15 at 3:49 p.m., indicated "It is the policy of [name of company] to monitor the resident's nutritional intake at each meal. This is recorded on a food intake record in percent consumed. 0%=nothing eaten, 25%=1/4 of total meal eaten, 50%=1/2 of total meal eaten, 75%=3/4 of total meal eaten, 100%=all eaten...Significant weight loss is defined as: 5% in 1 month, 7.5% in 3 months, 10% in 6 months...</p>			
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F 0327 SS=E Bldg. 00	<p>Once the weight loss is verified, nursing will notify the RD/CDM (Certified Dietary Manager) in writing...."</p> <p>3.1-46(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview and record review, the facility failed to ensure residents received sufficient fluid intake amounts for 4 of 6 residents reviewed for hydration. (Residents #34, #3, #91 and #131)</p> <p>Findings included :</p> <p>1. On 1/2/2015 11:08 a.m., the record review for Resident # 34 was completed. Diagnoses, included but were not limited to, Alzheimer's disease, monoarthritis, macular degeneration, and depression.</p> <p>The resident's care plan dated 3/7/06 indicated, "...At risk for dehydration related to daily diuretic- CHF [Congestive Heart Failure]-Alzheimer's- Target date 10/29/14</p> <p>1) Monitor for edema (11/8/13) 2) Administer medications as ordered</p>	F 0327	<p><b>Tag #327</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident # 34, #3, #91, and #131 have been reviewed and fluid amount calculated to maintain proper hydration and health. Resident #34, #3, #91, and #131 fluid intakes are monitored daily.</p> <p><b>II. The facility will identify other residents that may</b></p>	02/07/2015

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	<p>(3/7/06)</p> <p>3) Encourage fluids throughout the day</p> <p>4) Monitor for signs and symptoms of dehydration. document</p> <p>5) monitor labs, report any abnormal</p> <p>6) monitor weight as ordered</p> <p>7) Notify MD and family as needed...."</p> <p>The Nutrition Assessment dated 10/16/14, indicated the resident was to receive 1300 milliliters average fluids per day.</p> <p>The most recent MDS (Minimum Data Set) assessment dated 10/22/14, indicated the resident had functional impairment which prevented independent access to fluids and used diuretics and/or laxatives and resident was at risk for dehydration.</p> <p>The Center for Medicare and Medicaid Services Site Operational Manual dated 1/7/11, on page 329, indicated, "...a general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kilograms times 30 cc [or milliliters] [2.2 pounds = 1 kilogram] except residents with renal or cardiac distress...."</p> <p>November 6, 2014, the resident weight was 121.6 pounds, so would require 1,650 milliliters (ml) daily.</p> <p>December 6, 2014, the resident weight</p>		<p><b>potentially be affected by the deficient practice.</b></p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Resident's hydration needs to be assessed by Registered Dietician or designee upon admission, quarterly, and with significant change.</p> <p>Nursing, Activities, and Therapy staff to be re-educated on offering, keeping in reach, and documentation of fluids.</p> <p>Resident's fluid intakes to be monitored daily to determine if</p>	

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	<p>was 119.3, so would require 1,620 milliliters daily. January 5, 2015, the resident weight was 114.6, so would require 1,560 milliliters daily.</p> <p>The daily fluid intakes documentation were not totaled daily and indicated : December 2014</p> <p>12/1/14 : 9:18 a.m.=480 +270 ml Total = 750 ml</p> <p>12/2/14 : 9:41 a.m.=480 ml +270 ml 8:58 p.m.= 540 ml Total = 1,290 ml</p> <p>12/3/14 : 9:20 a.m. = 240 ml + 270 ml 10:00 p.m.= 240 ml Total = 750 ml</p> <p>12/7/14 : 9:58 a.m. = 480 ml + 270 ml 6:30 p.m.= 410 ml Total = 1,160 ml</p> <p>12/8/14 : 8:36 p.m. 480 ml + 270 ml Total = 750 ml</p> <p>12/10/14 : 2:03 p.m. = 281 ml + 270 ml 3:00 p.m. = 480 ml 9:10 p.m.= 360 ml</p>		<p>fluid recommendations are met. If fluid recommendations are not met the Interdisciplinary team will review cause and initiate interventions as needed.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON/Designee will audit resident's fluid intakes to be daily with initiation of intervention as needed.</p> <p>DON/Designee will audit resident's room to for availability and ease of access of fluids daily times 4 weeks, weekly times 4 weeks, monthly times 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>	

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	Total = 1,391 ml		<b>V. Plan of Correction completion date.</b>  Plan of Completion date is February 7, 2015	
12/11/14:	10:18 a.m. = 360 ml +270 ml			
	9:14 p.m. = 500 ml Total = 1,130 ml			
12/12/14:	1:08 p.m. 960 ml + 270 ml Total = 1,230 ml			
12/14/14 :	10:04 a.m. =120 ml + 270 ml			
	1:50 p.m. = 220 ml 6:33 p.m. = 220 ml Total = 830 ml			
12/15/14:	10:12 a.m. = 240 ml 1: 23 p.m. =270 ml 9:30 p.m. = 240 ml Total = 750 ml			
12/19/14:	10:50 a.m. = 240 ml + 270 ml			
	11:51 a.m. 480 ml 1:52 p.m. = 240 ml Total = 1,230 ml			
12/20/14 :	1:24 p.m. = 720 ml + 270 ml Total = 990 ml			
12/22/14 :	10:25 a.m. = 480 ml + 270 ml			
	2:03 p.m. 240 ml			

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	Total = 990 ml			
	12/25/14 : 9:27 a.m. = 480 ml + 270 ml 1:36 p.m. = 480 ml Total = 1,230 ml			
	12/26/14 : 8:39 p.m. =480 ml + 270 ml Total = 750 ml			
	12/27/14: 10:01 a.m.= 240 ml + 270 ml 1:00 p.m. = 220 ml 6:44 p.m. = 320 ml Total = 1,050 ml			
	12/28/14 : 1:57 p.m. = 220 ml 1:58 p.m. = 320 ml 6:21 p.m.= 180 ml Total = 990 ml			
	12/30/14: 9:26 a.m. = 120 ml + 270 ml 1:50 p.m.= 480 ml Total = 870 ml			
	12/31/14 10:19 a.m. = 75 ml 2:13 p.m. = 360 ml Total = 435 ml			
	1/2/15: 2:36 p.m.= 800 ml + 270 ml Total = 1,070 ml			

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	<p>1/3/15 : 9:52 a.m. = 240 ml + 270 ml</p> <p>1:39 p.m.= 480 ml</p> <p>9:06 p.m.= 240 ml</p> <p>Total = 1,230 ml</p> <p>1/4/15: 10:11 a.m.= 240 ml + 270 ml</p> <p>3:11 p.m. = 240 ml</p> <p>8:30 p.m. = 480 ml</p> <p>Total = 1,230 ml</p> <p>1/5/15: 2:00 p.m. = 480 ml + 270 ml</p> <p>2:45 p.m. = 240 ml</p> <p>Total = 990 ml</p> <p>An observation of the resident on 1/2/2015 at 11:43 a.m., the resident had a foam cup at the bedside with "1-2-15 AM" marked on it and the wrapper was still on the straw. In talking with the resident her mouth appeared dry and lips and tongue were sticking to roof of mouth when she would speak.</p> <p>On 1/2/2015 at 4:43 p.m., the family member visiting indicated he visits and brings the resident a soda or frappucino when he can because she doesn't like water. He indicated she usually says she is thirsty.</p>			

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	<p>On 1/07/2015 at 9:51 a.m., the Director Of Nursing indicated they had not known the resident did not like water.</p> <p>2. On 1/6/15 at 11:19 a.m., Resident #3's record was reviewed. Diagnoses included, but were not limited to, dysphasia, cognitive deficits, lack of coordination, aphasia, hypertension, diabetes mellitus, constipation, and urinary tract infections.</p> <p>On 12/31/14 at 10:45 a.m., the resident did not have fluids available in her room. She had a sign posted next to her door that indicated "Nectar Thick Liquids Only Please No Thin Water!" The resident had saliva in her mouth and wet mucous membranes.</p> <p>On 1/2/15 at 11:39 a.m., the resident had a Styrofoam cup filled half full with a clear thickened liquid with a straw and a piece of paper covering the top of the straw sitting on her bedside table. She also had a sippy cup full of a clear thickened liquid sitting on her bedside table next to the Styrofoam cup. The date marked on the Styrofoam cup was 1/2/15 and a.m., marked on the top edge of the cup.</p> <p>On 1/2/15 at 2:20 p.m., the resident had a Styrofoam cup of clear thickened fluid filled to the top dated 1/2/15 and an E</p>			

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	<p>(Evening shift) was marked on the top edge of the cup. Then under that, NTL (nectar thickened liquids) was marked on the top edge of the cup. The cup was sitting on the counter by the bathroom, out of the resident's reach. There was no straw in the cup.</p> <p>On 1/5/15 at 9:30 a.m., the resident did not have fluids available in her room.</p> <p>On 1/5/15 at 3:07 p.m., the resident had a sippy cup with a clear thickened liquid filled to the top with a straw in the cup sitting on her bedside table. The bedside table was sitting across the room by the window out of the resident's reach.</p> <p>On 1/6/15 at 9:40 a.m., the resident did not have fluids available in her room.</p> <p>The "Admission Nursing Assessment" dated 11/6/14, indicated the dehydration risk factors was urinary tract infections, cognitive impairment, which prevented communicating needs or the resident from obtaining fluids independently, the use of thickened liquids and the use of diuretics and/or laxatives and she was at risk for dehydration.</p> <p>The MDS (Minimum Data Set) nursing assessment dated 12/1/14, indicated the dehydration assessment risk factors was</p>			

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	<p>urinary tract infections and the use of thickened liquids. She was at risk for dehydration.</p> <p>The resident's Physician orders dated January 2015, included, but were not limited to the following orders: 11/6/14--Nectar thickened liquids</p> <p>The meal intake records for consumption of fluids for December 2014 and January 2015, included but were not limited to the following daily fluid amounts that were not totaled by the staff.</p> <p>12/01/14--475 ml 12/04/14--827 ml 12/06/14--880 ml 12/08/14--720 ml 12/10/14--380 ml 12/13/14--1600 ml 12/14/14--1080 ml 12/15/14--1300 ml 12/17/14--1175 ml 12/19/14--1280 ml 12/20/14--640 ml 12/21/14--830 ml 12/22/14--1320 ml 12/24/14--1380 ml 12/25/14--1140 ml 12/26/14--1120 ml 12/27/14--1020 ml 12/28/14--1440 ml 12/29/14--1440 ml 12/30/14--700 ml</p>			

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	<p>01/01/15--400 ml 01/02/15--1080 ml 01/03/15--800 ml 01/04/15--400 ml 01/05/15--1520 ml</p> <p>Resident #3's admission "Nutritional Assessment Comprehensive" dated 10/23/14, indicated she drank nectar thickened liquids. The resident averaged 1200 ml (milliliters) of fluids a day. Her "Nutritional Status" indicated her total calories and fluids required to meet the estimated needs were 1700-2100 kcal (kilocalorie)/ml of fluids a day.</p> <p>During an interview on 12/31/14 at 10:45 a.m., Resident #3 indicated she did not get anything to drink between meals. She indicated she got thirsty between meals.</p> <p>During an interview on 1/6/15 at 2:40 p.m., LPN #2 indicated each shift passed water after they came onto their shift. She indicated she was not aware this resident had not had fluids available to her between meals.</p> <p>3. On 1/6/15 at 4:51 p.m., Resident #91's record was reviewed. Diagnoses included, but were not limited to, dementia without behavioral disturbances, dysphagia, adrenal disorder, hypertension, iron deficiency anemia,</p>			

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	<p>constipation.</p> <p>On 12/30/14 at 1:48 p.m., the resident had a Styrofoam cup filled with water dated 12/30/14 with a G marked on the top edge of the cup with a straw, sitting on her nightstand out of her reach.</p> <p>On 12/31/2014 at 9:52 a.m., the resident had a Styrofoam cup with a straw, filled with water dated 12/30/14, with a G (Initial) marked on the top edge of the cup sitting on her nightstand. No ice was in the cup.</p> <p>On 1/2/15 at 11:01 a.m., the resident had a Styrofoam cup full of water sitting on her nightstand out of her reach dated 1/2 and it had a N marked on the top edge of the cup . The cup had a straw with the paper covering the top of the straw. The cup was sitting on the resident's nightstand.</p> <p>On 1/2/15 at 2:13 p.m., the resident had a Styrofoam cup full of water sitting on her nightstand out of her reach dated 1/2 and it had a N marked on the top edge of the cup. The cup had a straw with the paper covering the top of the straw.</p> <p>On 1/2/15 at 2:43 p.m., CNA #6 gave the resident fresh water, but did not offer her a drink of water.</p>			

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	<p>On 1/2/15 at 3:39 p.m., CNA #7 and CNA #8 gave the resident pericare and changed her brief and did not offer her a drink of water.</p> <p>On 1/5/15 at 9:20 a.m., the resident drank 3 (12 ounce) glasses of milk for breakfast.</p> <p>On 1/5/15 at 8:45 a.m., the resident had a Styrofoam cup full of water dated 1/4/15, with a.m., marked on the top edge of the cup. The cup had a straw in it with a piece of paper covering the top of the straw. The cup was sitting on her nightstand.</p> <p>On 1/5/15 at 3:05 p.m., the resident had a Styrofoam cup full of water and ice dated 1/5/15, with an E marked on the top edge of the cup. The cup had a straw in it sitting on her nightstand out of the resident's reach.</p> <p>On 1/6/15 at 9:36 a.m., the resident did not have fluids available in her room.</p> <p>The resident's Physician orders dated January 2015, included, but were not limited to the following orders: 11/26/14--Thin liquids 12/24/14--Senexon-S 816-50 mg Po BID for constipation</p>			

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	<p>The annual MDS Nursing Assessment dated 12/9/14, indicated the risk factors for dehydration were cognitive impairment, which prevented communicating needs or obtaining fluids independently and use of diuretics and/or laxatives and she was at risk for dehydration.</p> <p>The resident's "Dehydration Assessment" dated 12/5/14, indicated the risk factors for dehydration were cognitive impairment, which prevented communicating needs or obtaining fluids independently and she was at risk for dehydration.</p> <p>The meal intake records for consumption of fluids for December 2014 and January 2015, included, but were not limited to the following daily fluid amounts that were not totaled by the staff.</p> <p>12/01/14--480 ml 12/02/14--No fluids found documented 12/03/14--360 ml 12/04/14--1140 ml 12/05/14--330 ml 12/06/14--700 ml 12/07/14--720 ml 12/08/14--120 ml 12/09/14--1280 ml 12/10/14--1280 ml 12/11/14.--200 ml</p>			

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	<p>12/12/14--980 ml 12/13/14--800 ml 12/14/14.--360 ml 12/15/14--No fluids documented for this date 12/16/14.--720 ml 12/17/14.--480 ml 12/18/14--1100 ml 12/19/14.--820 ml 12/20/14--120 ml 12/21/14--840 ml 12/23/14--240 ml 12/24/14--1040 ml 12/25/14--1440 12/26/14--1080 ml 12/27/14-600 ml 12/28/14--960 ml 12/29/14--980 ml 12/30/14.--240 ml 12/31/14--960 ml 01/03/15--720 ml 01/04/15--700 ml 01/05/15--720 ml</p> <p>Resident #91's annual "Nutritional Assessment Comprehensive" assessment dated 12/3/14, indicated she averaged 1500 ml of fluids a day. Her "Nutritional Status" indicated her total calories and fluids required to meet the estimated needs were 1450-1750 kcal/ml of fluids a day.</p> <p>During an interview on 1/5/15 at 9:20</p>			

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	<p>a.m., an unidentified RN assisting the resident to eat indicated she was really thirsty this a.m. She indicated she will drink 3-4 milks at meals.</p> <p>4. On 1/6/15 at 5:07 p.m., Resident #131's record was reviewed. Diagnoses included, but were not limited to, altered mental status, dysphagia, chronic renal failure, hypertension, dementia without behavioral disturbances, diarrhea, depressive disorder, constipation, edema, microscopic hematuria, urine retention.</p> <p>On 12/30/14 at 9:52 a.m., the resident had a Styrofoam cup filled half full with tan colored thickened liquid with 12/29/14, and 2nd shift marked on the top of the edge of the cup. The cup was sitting on the resident's bedside table, which was pushed up against his privacy curtain out of his reach.</p> <p>On 12/30/14 at 1:40 p.m., the resident had a Styrofoam cup with a clear colored thickened liquid with the date 12/30/14, marked on the top edge of the cup, sitting on his nightstand out of his reach.</p> <p>On 12/31/14 at 9:41 a.m., the resident had a Styrofoam cup with a clear colored liquid with 12/30/14, marked on the top edge of the cup, sitting on his nightstand out of his reach.</p>			

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	<p>On 1/2/15 at 11:13 a.m., the resident did not have fluids available in his room.</p> <p>On 1/2/15 at 2:53 p.m., the resident had a Styrofoam cup on his table with a clear colored thickened fluid with a straw in the cup with 1/2/15 and an e marked on the top edge of the cup sitting on his nightstand.</p> <p>On 1/5/15 at 8:50 a.m., the resident had a Styrofoam cup full with an orange colored thickened liquid with 1/4/15, and a N marked on the top edge of the cup sitting on his nightstand. No straw was in the cup.</p> <p>On 1/5/15 at 9:37 a.m., the resident had a Styrofoam cup full with an orange colored thickened liquid with 1/4/15 and a N marked on the top edge of the cup sitting on his nightstand. No straw was in the cup.</p> <p>On 1/5/15 at 3:15 p.m., the resident had a Styrofoam cup full with an orange colored thickened liquid with 1/4/15, and a N marked on the top edge of the cup sitting on his nightstand. No straw was in the cup.</p> <p>The "Dehydration Assessment" dated 10/8/14, indicated the resident did not</p>			

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	<p>have any dehydration assessment risk factors for the risk factors and he was not at risk for dehydration.</p> <p>The quarterly nursing assessment dated 10/23/14, indicated the resident did not have any dehydration assessment risk factors and he was not at risk for dehydration.</p> <p>The residents Physicians orders dated January 2015, included but were not limited to the following orders: 12/19/14--Honey thickened liquids 12/29/14--Health shake with all meals TID (Three times a day)</p> <p>The meal intake records for consumption of fluids for December 2014 and January 2015, included these fluid amounts, but were not limited to the following daily fluid amounts that were not totaled by the staff.</p> <p>12/01/14--500 ml 12/02/14--480 ml 12/03/14--600 ml 12/04/14--1160 ml 12/05/14--60 ml 12/06/14--780 ml 12/07/14--800 ml 12/08/14--360 ml 12/09/14--1440 ml 12/10/14--300 ml 12/11/14--780 ml</p>			

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	<p>thickened liquids. The resident averaged 1200 ml of fluids a day. His "Nutritional Status" indicated his total calories and fluids required to meet the estimated needs were 1900-2200 kcal/ml of fluids a day.</p> <p>During an interview on 1/7/15 at 9:30 a.m., the Director of Nursing (DON) indicated fluid intake amounts were documented in the computer. The supplement intake amounts were documented either in the computer or on the EMAR (Electronic Medication Administration Record) under the supplement order. She indicated the fluid intakes were primarily documented by the nurses. She indicated fresh water should have been passed every shift. She indicated she expected the resident's who can not reach their fluids to be offered water during care and when the water was being passed out to the residents. She indicated that fluids were encouraged by attempting to offer them when able if the resident would take the fluids. She indicated when a resident refused fluids, she expected them to approach the resident later and offer them fluids. She indicated there were no formal alternatives for a resident who refused fluids such as; substituting puddings, ice cream or jello to replace the fluids.</p>			

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F 0329 SS=D Bldg. 00	<p>During an interview on 1/8/15 at 9:40 a.m., the DON with the RD (Registered Dietician), Administrator and DDS (Director of Dietary Services) were in attendance. The DON indicated Resident #131 was at risk for dehydration on 10/8/14. She indicated at the time the "Dehydration Assessment," was done he was cognitively impaired and could not reach his fluids independently, so his "Dehydration Assessment" was done inaccurately.</p> <p>A current policy titled "Nutrition &amp; Hydration At Risk Program" undated, provided by the DON on 1/8/15 at 3:49 p.m., indicated "...Residents who are found to be at risk are placed on a Nutritional/Hydration Risk Program... Fluid intake will be documented on all residents for the 1st seven days of the resident's admission to assist in hydration monitoring...."</p> <p>3.1-46(b)</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</p>			

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	<p>for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to have a supportive diagnosis and the facility failed to ensure specific behaviors were identified and quantitatively monitored to support the use of psychotropic medications for 2 residents. This deficient practice affected 2 of 6 residents reviewed for Unnecessary Medications. (Resident #131 and #97).</p> <p>Findings include:</p> <p>1. During an observation on 12/30/2014 at 1:30 p.m., Resident #131 was observed in the hallway with his eyes closed, oxygen on and not responding to verbal stimuli.</p> <p>Resident #131's record was reviewed</p>	F 0329	<p><b>Tag #329</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Gradual dose reductions of antipsychotics have been initiated on resident #131 and resident #97.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the</b></p>	02/07/2015

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	<p>01/05/2015 at 3:34 p.m. Diagnoses, included but were not limited to, altered mental status, weakness, dysphagia (difficulty swallowing), paralysis agitans (Parkinson's disease: a degenerative disorder of the central nervous system), and dementia.</p> <p>The Physician's order recap (recapitulation) for January 2015 indicated the resident's medications included, but was not limited to, the following medications:</p> <p>Seroquel (an anti-psychotic medication) one 25 mg (milligrams) tablet orally, every morning at 7 a.m. Seroquel (generic name -- quetiapine) one 50 mg tablet orally, at bedtime; 7 p.m. Ativan (an anti-anxiety medication) 0.5 mg one tablet orally every 4 hours as needed.</p> <p>The Physician's order recap for December 2014 indicated the resident was ordered, but was not limited to, the following medications:</p> <p>Seroquel 25 mg one tablet orally every morning at 7 a.m. Seroquel 100 mg one tablet orally every day at 7 p.m. Ativan (generic name -- lorazepam) 0.5</p>		<p><b>deficient practice.</b></p> <p>Residents receiving psychotropic medication have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Residents receiving psychotropic medication have been reviewed and plan of care updated to reflect appropriate supporting diagnoses and specific behavior monitoring. The diagnosis lists have been updated with the supporting diagnosis. The order for the antipsychotic medication has been reviewed for the supporting diagnosis.</p> <p>All residents currently in the facility and receiving antipsychotics, antidepressants, and/or anti-anxiety medications will be reviewed by the physician for a potential GDR per the</p>	

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	<p>mg orally every 4 hours as needed.</p> <p>During an interview on 01/06/2015 at 11:07 a.m., the SSD (Social Service Director) indicated he was not sure what the resident's diagnosis for receiving anti-psychotic medication was. He thought it was hallucinations, but he would need to look it up and provide a copy of the record.</p> <p>The record of Resident #131's medication review for "unnecessary" medications by pharmacy that was provided by the facility was reviewed on 01/06/2015 at 12:30 p.m., and indicated the pharmacy did a medication regimen review in May 2014 with a recommendation. This was the only pharmacy recommendation provided by the facility.</p> <p>The pharmacist's review was dated 5/31/2014, indicated the following for Resident #131: "...This visit determined the following residents with potentially unnecessary medication orders...[Resident #131's name] Quetiapine Fumarate [Seroquel] (Quetiapine Fumarate Tab 100 Mg) Order: Date 4/19/2014 100 mg w[with] / 25 mg = 125 mg qHS[every bedtime] Comments: Black box warning citing increased risk of all-cause mortality in the geriatric population who receive</p>		<p>Behavior Management Policy.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>The Social Service Director/designee will audit documentation, orders, diagnosis list, and care plans on residents receiving antipsychotics, antianxiety, and antidepressant medication, with emphasis on an adequate indication for the use of the medication and targeted behaviors weekly x 4 weeks and monthly thereafter.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>		

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	<p>antipsychotics or atypical antipsychotics for dementia-related diagnoses...increased from 100 to 125 mg 4/14...."</p> <p>The resident's progress notes for 6/25/2014 indicated the following: "received response from [name of doctor's] office to DC [discontinue] Seroquel by gradual decrease of 25 mg q [every ]4 days...."</p> <p>The resident's record indicated under progress notes: "...07/17/2014...family requested through SS [Social Service] that we restart Seroquel d/t [due to] possible hallucinations, spoke with [family member] regarding concerns, family states he says he sees spiders, feels he is more agitated than previous, etc. spoke with nursing staff and no one has noted a change in behaviors since Seroquel DCd [discontinued] spoke with [family member] about resident possibly seeing [Psychiatrist's name] for eval [evaluation] and treatment regarding concerns but [family member] felt psychiatry was unnecessary..., message sent to [Physician] regarding above concerns with [family member's] name and phone number, ...awaiting response...."</p> <p>The resident's November 2014, physician</p>		<p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is February 7, 2015</p>	
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	<p>order recap, record indicated the resident was ordered Seroquel 100mg to take orally once a day at 7 p.m., starting on 9/30/2014 - 12/29/2014 (DC date) and Seroquel 25 mg to take orally once in the morning at a.m., starting on 10/01/2014.</p> <p>The resident's January 2015, physician order recap, record indicated the resident was to take Seroquel 50 mg orally at bedtime at 7 p.m., starting on 12/29/2014 - open ended and Seroquel 25 mg to take orally once in the morning at 7a.m., starting 10/01/2014 - open ended.</p> <p>Resident #131's record lacked any documentation regarding specific behavior monitoring for the use of antipsychotic medication or indication for its use.</p> <p>During an interview on 01/8/2015 at 1:20 p.m., CNA #18 indicated the resident had been more alert and talking in the past week than he has been in a long time.</p> <p>As of 1/8/2015 at 5 p.m., at exit, no more information was provided by the facility, regarding this resident's psychotropic medications and their indication for use, or behavior monitoring for specific behaviors to support the use of anti-psychotic medication for this resident.</p>			

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F 0364 SS=D Bldg. 00	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to serve palatable and attractive looking foods at the appropriate temperature for 1 of 1 resident that were reviewed for food quality. (Resident #28)</p> <p>Findings include:</p> <p>1. On 1/2/15 at 12:28 p.m., the last tray was observed being removed from the East hallway room tray cart. The foods on the food tray were tested for appropriate temperature, palatability and attractiveness. At that time the Dietary Manager was observed testing the temperature of the foods and the temperatures were as follows: The coleslaw temperature was 46 degrees Fahrenheit (F). The rosemary potatoes temperature was 139 degrees F. The fish square on the sandwich temperature was 146 degrees F.</p> <p>The palatability of the coleslaw was observed to taste slightly cool and</p>	F 0364	<p><b>Tag #364</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #28 receives meals/food at proper temperatures</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic</b></p>	02/07/2015

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	<p>crunchy. The rosemary potatoes was observed to taste lukewarm, seasoned and soft to chew. The fish square was observed to taste lukewarm and soft to chew. The bun for the fish sandwich was observed to taste lukewarm and soft.</p> <p>The attractiveness of the coleslaw was observed to look colorful and fresh. The rosemary potatoes was observed in wedges. The fish square was observed a light brown color.</p> <p>During an interview at that time, the Director of Dietary Services (DDS) indicated the coleslaw was served at a warm temperature.</p> <p>On 1/2/15 at 12:40 p.m., the last tray was observed being removed from the Rehabilitation dining room. The foods on the food tray were tested for appropriate temperature, palatability and attractiveness. At that time the Dietary Manager was observed testing the temperature of the foods and the temperatures were as follows: The coleslaw temperature was 37 degrees F. The rosemary potatoes temperature was 114 degrees F. The fish square on the sandwich temperature was 108 degrees F.</p>		<p><b>changes to ensure that the deficient practice does not recur.</b></p> <p>The Facility will prepare foods according to the menu and standardized recipes provided by CarDon and at the appropriate temperature for each food item.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>The DM/Designee will audit one meal, to include 3 room trays 7 days per week for 4 weeks for proper temperatures. Then 3 room trays 3 days a week x 4 weeks, then 3 room trays weekly x 4 weeks, then 3 room trays monthly x 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>The DM/Designee will complete</p>		

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	<p>The palatability of the coleslaw was observed to taste slightly cold and crisp and crunchier than the coleslaw from the East hallway tray. The rosemary potatoes was observed to taste lukewarm, seasoned and soft to chew. The fish square was observed to taste lukewarm and tough to chew. The bun for the fish sandwich was observed to taste cool and soft.</p> <p>The attractiveness of the coleslaw was observed to look colorful and fresh. The rosemary potatoes was observed in wedges. The fish square was observed a darker brown color with the bottom of the fish square even darker in color than the fish square compared to the fish square on the East hallway room tray.</p> <p>During an interview at that time, the DDS indicated the rosemary potatoes and the fish square was not hot enough.</p> <p>During an interview on 1/2/15 at 2:30 p.m., the DDS indicated the holding temperatures of food should be 135 degrees F or higher when served.</p> <p>During an interview on 1/2/15 at 5:20 p.m., the Dietary Manager indicated the cold food temperatures should be 41 degrees F and lower when served.</p>		<p>random interviews including a sample of 3 residents, 1 residing on East unit, West unit and the Rehab unit weekly x 4 weeks, monthly x 4 months. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is February 7, 2015</p>	

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F 0371 SS=F Bldg. 00	<p>2. On 1/5/15 at 11:34 a.m., Resident #28's record review was completed. Diagnoses included, but were not limited to, dysphagia, iron deficiency anemia, congestive heart failure, chronic kidney disease Stage III, osteoporosis, leukocytosis, constipation, pressure ulcer buttock, and esophageal reflux.</p> <p>During an interview on 12/31/14 at 2:33 p.m., the resident indicated she did not like the food she was served at the facility. She indicated she would not feed a hog what they feed them here. She indicated she had baked beans for lunch today and they were pork and beans out of a can without any seasoning on them. She indicated the meat was hard to chew. She indicated the food was served cold. The CNA's stood in her room after they delivered her tray, until she tasted the food, because they would have to warm her food up in the microwave for her.</p> <p>3.1-21(a)(3)</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</p>			
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	<p>Based on observation, interview and record review, the facility failed to ensure foods were stored and served under sanitary conditions for 109 of 110 residents served from the kitchen.</p> <p>Findings include.</p> <p>1. On 12/29/14 at 12:03 p.m., a lunch meal dining room observation was completed.</p> <p>The following dates and times staff members washed their hands during the meal service:</p> <p>On 12/29/14 at 12:21 p.m., RN #11 washed her hands for 10 seconds. On 12/29/14 at 12:25 p.m., LPN #12 washed her hands for 15 seconds. On 12/29/14 at 12:27 p.m., CNA #13 washed her hands for 13 seconds. On 12/29/14 at 12:31 p.m., LPN #14 washed her hands for 17 seconds. On 12/29/14 at 12:42 p.m., CNA #15 washed her hands for 12 seconds. On 12/29/14 at 12:44 p.m., CNA #16 washed her hands for 5 seconds. On 12/29/14 at 12:45 p.m., CNA #13 washed her hands for 14 seconds. On 12/29/14 at 12:47 p.m., LPN #14 washed her hands for 8 seconds. On 12/29/14 at 12:49 p.m., LPN #17 washed her hands for 3 seconds. On 12/29/14 at 12:53 p.m., LPN #17</p>	F 0371	<p><b>Tag #371</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>No residents found to be affected by the alleged deficient practice.</p> <p>CNA #13 was reeducated on appropriate handling of resident's food.</p> <p>Food improperly stored in the freezer, walk in cooler, and prep refrigerator was disposed of 12/29/14.</p> <p>The prep area and dry storage area were cleaned 12/29/14.</p>	02/07/2015

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	<p>washed her hands for 4 seconds. On 12/29/14 at 12:57 p.m., CNA #15 washed her hands for 4 seconds.</p> <p>On 12/29/14 at 12:40 p.m., CNA #13 buttered bread with a knife for a resident without touching it. She picked the bread up with both hands, folded it and handed it to him.</p> <p>During an interview on 12/29/14 at 1:45 p.m., the Administrator indicated the staff should have washed their hands for 20 seconds. He indicated staff should not have touched resident's food with their bare hands.</p> <p>2. The kitchen tour began on 12/29/14 at 9:56 a.m., with the Dietary Manager in attendance.</p> <p>a. The freezer had 5 meat patties that were not labeled or dated and were sitting inside a box of diced white meat that had the lid open and the blue plastic wrap was not covering the meat. The diced meat was shriveled, pale colored and had ice crystals on the top pieces.</p> <p>During that time the Dietary Manager (DM) indicated the meat patties were chicken patties and were not suppose to be in the box. He indicated the white diced meat was diced chicken and the</p>		<p>The mixer and meat slicer were covered when not in use.</p> <p>Cold storage plastic pans were dried and properly stored 12/29/14.</p> <p>The stove and ovens were cleaned on 12/29/14.</p> <p>The deep fryer was cleaned on 12/29/14.</p> <p>Pellet warmer was cleaned on 12/29/14.</p> <p>Toaster was cleaned on 12/29/14.</p> <p>RN #11 was re-educated on hand washing procedure on 12/29/14</p> <p>LPN #12 was re-educated on hand washing procedure on 12/29/14</p> <p>CNA #13 was re-educated on</p>	

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	<p>box should have been closed.</p> <p>b. The walk-in cooler had the following food items that were not dated and/or labeled or were past the use by date. The DM indicated the identity and amount of the following food items: 1 quart jello in a metal pan dated 12/15. 3 quarts ham salad in a plastic container dated 12/23. 3 pounds beef dated 12/22 sitting on a metal pan. A 10 pound roll of ground beef thawed on a metal pan sitting next to two, 2 pound bags of frozen ground beef packages in plastic wrap and none of the three ground beef items were dated or labeled. When the DM turned over the unopened roll of ground beef to check for a date and label, the top of the beef was brown colored and the bottom of the beef was a red color with a red colored liquid in the bag. 2-3 pounds of a pork loin in a metal pan not dated.</p> <p>4 boxes of food and milk on the top shelves that were within more than 16 inches from the ceiling.</p> <p>During that time the DM indicated the foods should have been labeled and dated. He indicated the foods that were dated should have been thrown out if they</p>		<p>hand washing procedure on 12/29/14</p> <p>LPN #14 was re-educated on hand washing procedure on 12/29/14</p> <p>CNA #15 was re-educated on hand washing procedure on 12/29/14</p> <p>CNA #16 was re-educated on hand washing procedure on 12/29/14</p> <p>LPN #17 was re-educated on hand washing procedure on 12/29/14</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into</b></p>	

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	<p>were in the cooler past their use by date. He indicated leftover food could only be kept for 3 days after being placed in the cooler. He indicated the boxes of food and milk could not have been placed on the top shelves more than 16 inches from the ceiling.</p> <p>c. The prep refrigerator had the following food items that were not dated and/or labeled or were past the use by date. The DM indicated the identity and amount of the following food items: 4 bowls Strawberry yogurt was not dated or labeled was sitting on a serving tray stacked on top of a tray of mayonnaise condiment cups. 13 individual mayonnaise cups with no lids and partially covered with a piece of plastic wrap was not labeled or dated was sitting on a serving tray stacked on top of a tray of Italian dressings. 2 individual Italian dressing cups with no lids and partially covered with a piece of plastic wrap was not labeled or dated was sitting on a serving tray stacked on top of a tray of Ranch dressings. 3 individual Ranch dressing cups with no lids and partially covered with a piece of plastic wrap was not labeled or dated was sitting on a serving tray stacked on top of a tray of French dressings. 4 individual French dressing cups with no lids and partially covered with a piece of</p>		<p><b>place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Facility staff was reeducated on correct hand washing procedure and food/plate handling during meal service. Signs were posted at hand washing stations to remind staff of the appropriate length of time to wash hands.</p> <p>Cleaning schedules re-initiated for kitchen including equipment, storage areas, prep areas, and service areas. Dietary staff was reeducated on appropriate food storage, sanitation, and cleaning of equipment and kitchen areas.</p> <p><b>IV The facility will monitor the corrective action by implementing the following</b></p>	

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	<p>plastic wrap was not labeled or dated was sitting on the bottom of the refrigerator shelf.</p> <p>2 cups of brown gravy in a plastic container was not labeled or dated.</p> <p>1 quart of apple pie filling in a plastic container dated 12/12.</p> <p>2 quarts applesauce in a plastic container dated 12/23.</p> <p>2 quarts biscuit gravy in a plastic container dated 12/25.</p> <p>30 individual sour cream cups with no lids were partially covered with plastic wrap was no labeled or dated was sitting on a serving tray on a refrigerator shelf.</p> <p>50 American cheese slices were wrapped in plastic wrap and were not labeled or dated.</p> <p>11 Roast beef slices in a metal pan were not labeled or dated.</p> <p>1 quart of "something" pureed (a brown substance) in a metal pan was not labeled or dated.</p> <p>1 quart Tapioca pudding in a plastic container was not labeled or dated.</p> <p>2 quarts Cranberry sauce in a metal pan was not labeled or dated.</p> <p>3 cups Tuna salad in a plastic container was dated 12/18 and unlabeled.</p> <p>6 quarts tossed salad with shredded cheese in a plastic bowl was not labeled or dated.</p> <p>1 quart mixed vegetables were not labeled or dated.</p>		<p><b>measures.</b></p> <p>The SDC/designee will perform a random audit of hand washing/handling of food at meal service 7 x week x 4 weeks, weekly x 4 weeks, then monthly x 4 months.</p> <p>The DM/Designee will perform a sanitation and food storage audit 3 x weekly x 4 weeks, weekly x 4 weeks, then monthly x 4 months.</p> <p>Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p><b>V. Plan of Correction completion date.</b></p>	

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	<p>2.5 quarts Sweet and Sour pork in a plastic container dated 12/22 and unlabeled.</p> <p>40 slices Old Fashioned Loaf lunchmeat was not labeled or dated.</p> <p>5 egg omelets in a metal pan was not labeled or dated.</p> <p>2.5 quarts Vanilla frosting in a plastic container dated 12/23 was not labeled.</p> <p>During an interview at that time, the DM indicated those food items should have been dated and labeled when placed in the prep refrigerator. He indicated the left over foods can only be in the refrigerator for 3 days then they had to be thrown out because they were expired.</p> <p>d. The prep area had whitish gray clumps attached to the ceiling and were hanging down from the ceiling. Above the dry storage door there was 3 long whitish gray strands attached from the ceiling hanging down.</p> <p>The DM indicated at that time that these whitish gray items were spider webs. He indicated the kitchen staff sweeps the ceiling for cobwebs annually or semi-annually.</p> <p>e. The mixer and meat slicer was not covered when not in use.</p>		<p>Plan of Completion date is February 7, 2015</p>	
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	<p>During an interview at that time, the DM indicated he knew these items were to be covered and he usually covered them with a trash bag.</p> <p>f. 2 cold storage plastic pans had beads of clear liquid between them sitting on the shelf where the dry dishes were sitting.</p> <p>The DM indicated at that time, the beads of liquid was water between the pans and there should not be any water between the pans. He indicated the water meant the staff did not allow the pans to dry before they placed them away.</p> <p>g. The top of the gas stove had burnt black debris on the burner grates and on the stove around the burners. Burnt on black debris on the grill part on the gas stove. The grates on the stoves had burnt black debris with pieces of food between the grates. The splash guard on the back of the stove had burnt brown and black debris on it. The oven under the gas stove had burnt black debris inside the oven and on the racks of the oven.</p> <p>h. The convection oven had burnt brown debris on the inside of the oven and on the inside and outside of the glass doors. The burnt brown debris had ran down the glass doors.</p>			

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	<p>i. The deep fryer basket was not covered and the grease was a dark brown color and was not be seen through. The deep fryer had brown burnt debris around the edge of the fryer.</p> <p>j. Pellet Warmer (holds the plates to keep them hot) for room trays had brown debris and brown burnt debris on the inside of it.</p> <p>k. The toaster had black burnt food debris on the top surface of the conveyor rack and the bottom of the toaster was sprinkled heavily with toaster crumbs.</p> <p>During an interview on 12/29/14 at 11:00 a.m., with the Administrator present, the DM indicated stove was cleaned one day last week, but he did not know for sure what day. He indicated all the equipment in the kitchen was on a weekly cleaning schedule. He indicated he did not know when the convection oven was used last or when it was cleaned last. A cleaning schedule for the equipment was requested at that time. The DM indicated at that time he did not have a weekly schedule made out at that time for the equipment to be cleaned routinely. The DM indicated the equipment had been cleaned last week, but he did not have any documentation to indicate they were</p>			

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	<p>cleaned. He indicated he did not know when the last time was the equipment was deep cleaned.</p> <p>The DM indicated he did not know when the deep fryer had been cleaned last or when the oil had been changed last. He indicated the oil should be a brown clear see through color. He indicated the toaster was cleaned after every use, but it had not been cleaned after breakfast this morning. He indicated it was deep cleaned weekly, but he could not remember when it was cleaned last.</p> <p>During an interview on 12/29/14 at 1:45 p.m., with the Administrator present, the Director of Dining Services (DDS) indicated the food that was found should have been labeled and dated. She indicated she was not sure if she wrote a policy or not, but the kitchen staff should have been sweeping for cobwebs monthly.</p> <p>A current policy titled "Handwashing/Handrub" undated, provided by the Administrator on 12/29/14 at 2:30 p.m., indicated "...Step...NOTE: Direct caregivers must rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers...."</p>			

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	<p>A current policy titled "Cleaning of Ceilings/Walls/Air Vents/Light Fixtures" dated 2012, provided by the DDS on 12/29/14 at 3:30 p.m., indicated "Policy: The ceilings, walls, air vents, and light fixtures in the Dining Services Department are kept free of food debris, stains and dust particles... Procedure: 1. The Director of Dining Services inspects the ceiling, walls, air vents and light fixtures monthly for cleaning/maintenance needs...."</p> <p>A current policy titled "Recommended Cleaning Frequency" dated 2012, provided by the DDS on 12/29/14 at 3:30 p.m., indicated "...Daily--Range Tops, Grill...Toaster... Weekly--...Range Hoods, Ovens, Steamer... Deep Fat Fryer... Monthly---...Ceilings...."</p> <p>A current policy titled "Cleaning Frequency of Equipment and Kitchen Area" dated 2012, provided by the DM on 12/29/14 at 11:15 p.m., indicated "Policy: Staff follow routine cleaning schedules that indicate frequency for cleaning equipment and kitchen areas. Procedure: 1. Dining Services staff consult and follow the 'Recommended Cleaning Frequency' and 'Cleaning Schedule' forms... 5. Surfaces of grills, griddles and similar cooking equipment are cleaned at least daily or at intervals</p>			

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NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060
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	<p>throughout the day. The cleaning schedule is based on the amount of soil accumulation and interruptions in production...."</p> <p>A current policy titled "Cleaning of Deep Fat Fryer" dated 2012, provided by the DM on 12/29/14 at 11:15 p.m., indicated "Policy: The deep fat fryer is cleaned according to a routine cleaning schedule...."</p> <p>A current policy titled "Cleaning of Meat Slicer/Food Chopper" dated 2012, provided by the DM on 12/29/14 at 11:15 p.m., indicated "...Procedure: 12. The entire unit is covered with clean plastic wrap to maintain cleanliness and sanitation."</p> <p>A current policy titled "Cleaning of Mixer" dated 2012, provided by the DM on 12/29/14 at 11:15 p.m., indicated "...Procedure: 8. The entire unit is covered with clean plastic wrap to maintain cleanliness and sanitation."</p> <p>A current policy titled "Cleaning of Oven" dated 2012, provided by the DM on 12/29/14 at 11:15 p.m., indicated "Policy: Ovens are kept clean and free of spills and grease. Procedure:.. Daily: 1. When a spill occurs, it is removed as soon as possible with hot cleaning</p>			

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F 0411 SS=D Bldg. 00	<p>solution...."</p> <p>A current policy titled "Cleaning of Toaster" dated 2012, provided by the DM on 12/29/14 at 11:15 p.m., indicated "Policy: Toasters are kept clean and free of any food particles...."</p> <p>3.1-21(h)(3)</p> <p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to assist a resident with obtaining dental services in a timely manner. This affected 1 of 1 residents reviewed for dental care. (Resident #163).</p> <p>Findings include:</p>	F 0411	<p><b>Tag #411</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been</b></p>	02/07/2015

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	<p>Resident # 163's record was reviewed on 01/02/2015 at 2:47 p.m. Diagnoses included, but were not limited to, cerebrovascular disease, left sided weakness, and lack of coordination.</p> <p>The resident's admission assessment or MDS(Minimum Data Set) assessment lacked any mention of the resident having broken or problem teeth.</p> <p>The resident's dental care plan dated 10/24/14 indicated the resident, "has a loss of natural teeth requiring upper dentures and lower partial..." and the goal, " will not develop oral / dental complications...assist w/oral hygiene as needed bid[two times per day]...obtain dental consult as warranted...."</p> <p>On 01/06/2015 at 4:34 p.m., during and observation and interview the resident lifted her bottom dental plate in her mouth up and a number of teeth looked worn which the resident indicated was from the partial plate rubbing against her remaining natural teeth. She indicated she needed to see a dentist and her family was looking to find one for her.</p> <p>In addition, she indicated no one in the facility looked in her mouth to see the extent of her worn teeth and need for professional dental attention. She did not</p>		<p><b>affected by the deficient practice.</b></p> <p>Resident #163 had an oral assessment completed on the Admission observation on 10/24/14</p> <p>Resident #163 has been offered dental services provided by the facility.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents with dentures or dental concerns have the potential to be affected by the alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p>	

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	<p>know she could get dental care with the help of the facility, so her daughter would hopefully find a dentist for her to go to.</p> <p>During an interview on 01/06/2015 at 4:59 p.m., LPN #2 indicated nursing should be looking in a person mouth upon admission to do a complete assessment.</p> <p>3.1-24(a)(1) 3.1-24(b)</p>		<p>Residents with dentures and/or dental concerns have been reviewed and services have been offered to resident as requested by resident and/or responsible party.</p> <p>Social Services will offer/inform resident and/or responsible party of availability of onsite dental services at initial care plan meeting following admission. Social service will obtain a written consent or declination of onsite dental services at that time. If resident chooses to seek outside dental services, social services will notify nursing of this and update resident's plan of care to reflect resident's preference.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Social Service Director/Designee will audit residents by interviewing 1 week following</p>	

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F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.		admission to ensure resident is aware of the availability of dental services weekly x 4 weeks, monthly x 4 months.  Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.  Facility Administrator will be responsible for ensuring compliance.  <b>V. Plan of Correction completion date.</b>  Plan of Completion date is February 7, 2015	
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	<p>Based on observation and interview the facility failed to maintain 2 resident's bathrooms in a safe and sanitary condition (Resident #127 and #113), and 4 resident's wheel chairs in a sanitary condition (Resident #91, #100, #109, and 166).</p> <p>Findings include:</p> <p>1. During an environmental observation, of the Memory Care area of the facility, on Tuesday 12/30/2014 at 12 :01 p.m., Resident #127's toilet paper holder had 1/2 of it on top of the resident's paper towel holder. Instead of 1/2 of the toilet paper holder being on the wall, there was a piece of wall sticking out where it had been.</p> <p>During an environmental observation, of Resident #127's bathroom, on Monday 1/05/2015 at 4:45 p.m., with CNA #3 in attendance, 1/2 of the toilet paper holder was observed still on top of the resident's paper towel holder and the wall with a piece of it sticking out.</p> <p>During an interview with CNA #3 at that time, she indicated a report to maintenance needed to be filled out, so it could be repaired. She did not know if anyone was aware of the wall and toilet paper holder problem.</p>	F 0465	<p><b>Tag #465</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Toilet paper holder for resident #127 was repaired 1/5/14.</p> <p>Trash in the bathroom of resident #113 was emptied 1/6/14.</p> <p>Wheelchairs were cleaned for resident's #91, #100, #109, and #166 per the wheelchair cleaning schedule.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p>	02/07/2015

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	<p>2. During an environmental observation, of the East Unit of the facility, on Tuesday 12/30/2014 at 2:30 p.m., Resident #113's bathroom trash can was overflowing and a couple disposable cups were observed laying on the floor beside the trash can. The cups had rolled approximately 6 to 8 inches away from the trash can. The small trash can had yellow isolation gowns sticking up over the top rim of it.</p> <p>During an observation on Tuesday 1/06/2015 at 10:35 a.m., with LPN #4 in attendance, Resident #113's bathroom trash can was observed full to the rim.</p> <p>At this time the LPN#4 indicated the CNAs and housekeeping are to empty the trash cans.</p> <p>3. During an initial observation, of the East Unit of the facility, on Tuesday 12/30/2014 at 2:05 p.m., Resident #91's wheel chair was observed with a white discoloration on top of the blue cushion. A smell of urine was present and food debris was observed under the wheel chair cushion.</p> <p>During an environmental and resident care equipment observation on Friday 1/02/2015 at 11:40 a.m., Resident #91's</p>		<p>All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Facility staff have been re-educated on procedure for identifying and reporting repairs as needed.</p> <p>Nursing and environmental staff have been reeducated regarding the emptying of trash in resident's rooms and bathrooms</p> <p>Nursing staff have been re-educated on the wheelchair schedule and identifying that equipment needs cleaned when visibly soiled or odor is apparent.</p>	

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	<p>wheel chair was observed with a white film residue on top of the blue cushion, a urine smell and food debris under the cushion were present.</p> <p>During an observation of resident care equipment on Monday 1/05/2015 at 11:25 a.m., Resident #91's wheel chair was observed with a white film residue on top of the blue cushion, the wheel chair's foot rest was on top of the cushion along with some food debris and a urine smell was present.</p> <p>On Tuesday 01/06/2015 at 10:35 a.m., with LPN #4 in attendance, Resident #91's wheel chair was observed with a white residue on top, a urine smell coming from it and under the cushion, which was sticking to the bottom of the wheel chair, there was food debris present.</p> <p>During an interview at this time, LPN#4 indicated it needed to be cleaned. A cleaning schedule was requested at this time.</p> <p>4. During an initial environmental tour observation, of the West Unit of the facility, on Monday 12/29/2014 at 10 a.m., Resident #100's wheel chairs were observed outside his room. The right arm rest on one was observed with a large</p>		<p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator/Designee will conduct random environmental resident room audit 3 x weekly x 4 weeks, weekly x 4 weeks, then, monthly x 4 months.</p> <p>DON/Designee will conduct random resident equipment audit 3 x weekly x 4 weeks, weekly x 4 weeks, then monthly x 4 months.</p> <p>Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>	

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	<p>area of wheel chair covering material missing / worn off and the back of another wheel chair seat was observed with large areas missing as if it had peeled / worn off.</p> <p>On Tuesday 01/06/2015 at 10:40 a.m. with LPN #5 present, Resident #100's wheel chairs were observed with dirt residue on them continued to have the areas that had peeled / worn off and were missing as in the the week before.</p> <p>During an interview at this time, LPN #5 indicated she normally had therapy or maintenance repair the wheel chairs.</p> <p>5. During an environmental observation, of the Rehabilitation Unit of the facility, on Wednesday 12/31/2014 at 11:57 a.m., Resident #109's wheelchair was observed with food debris under the wheel chair cushion.</p> <p>On Tuesday 01/06/2015 at 10:45 a.m., with LPN #2 in attendance, Resident #109's wheel chair was observed with crumbs under the wheelchair cushion.</p> <p>During an interview at this time, LPN #2 indicated the wheel chair was not really soiled (no urine or feces present) but would provide a cleaning schedule.</p>		<p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is February 7, 2015</p>	

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R 0000  Bldg. 00	<p>6. During an environmental observation, of the Rehabilitation Unit of the facility, on Wednesday 12/31/2014 at 2:05 p.m., Resident #166's wheelchair was observed with white colored debris under the seat cushion of the wheel chair.</p> <p>On Tuesday 01/06/2015 at 10:48 a.m., with LPN #2 in attendance, Resident #166's wheel chair was observed with crumbs under the wheelchair cushion.</p> <p>During an interview at this time, LPN #2 indicated she could provide a cleaning schedule.</p> <p>During an interview on Tuesday 01/06/2015 at 3:46 p.m., the Administrator indicated the facility does not have a policy and procedure regarding the cleaning and care of the resident's wheel chairs but each unit / area of the facility has a cleaning schedule for each day of the week according to room numbers.</p> <p>3.1-19(f)</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R 0000	January 23, 2015	

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			<p>Kim Rhoades, Director</p> <p>Long-Term Care Division</p> <p>Indiana State Department of Health</p> <p>2 North Meridian Street</p> <p>Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on January 8, 2015. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health and Living and The Lodge credible allegation of compliance. We allege compliance on February 7, 2015. We are requesting a desk review for this plan of correction.</p> <p>If you have any further questions, please do not hesitate to contact me</p>	

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			<p>at 317-770-3401.</p> <p>Sincerely,</p> <p>Justin P. Vogt H.F.A</p> <p>Administrator</p> <p>Submission of this plan of correction in no way constitutes an admission by Harbour Manor Health and Living and The Lodge or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is</p>	

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R 0092  Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the		prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on January 8, 2015. Please accept this plan of correction as Harbour Manor Health and Living and The Lodge credible allegation of compliance by February 7,2015.  This statement of deficiencies and plan of correction will be reviewed at the March Quality Assurance/Assessment Committee meeting.  Response to Survey Ending  January 8, 2015	

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	<p>transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review, the facility failed to attempt to have fire drills with the local fire department bi-annually.</p> <p>Findings included:</p> <p>The Administrator provided the fire drills information on 12/20/14 at 1:00 p.m.</p> <p>The documentation of fire drills had no documentation regarding attempts to call or a fire drill help with the local fire department.</p> <p>On 1/8/15 at 2:00 p.m., the Administrator indicated they had not held a fire drill with the fire department in the last year.</p>	R 0092	<p><b>RESIDENTIAL</b></p> <p><b>Tag #R092</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>No residents were adversely affected by this alleged deficient practice.</p> <p>The facility received an email on January 9, 2015 from the</p>	02/07/2015

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NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060		
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			<p>Noblesville Fire Inspector. The email stated that the Noblesville Fire Department was invited to, and did observe, a fire drill on September 11, 2014 at 9:45am.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>All residents have the potential to be affected by alleged deficient practice.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Maintenance director has been educated to invite local fire department in fire drills biannually and document fire department's response to request.</p>		

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			<p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator or designee will conduct an audit bi-annually for fire drill and local fire department invitation. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is February 7, 2015</p>	

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R 0216 Bldg. 00	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance</p> <p>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on interview and record review, the facility failed to ensure a self administration assessment and a Physician order was completed for a resident performing his own accuchecks and an assessment was completed for a resident who had fallen for 2 of 5 residents reviewed for assessments. (Residents #12 and #33)</p> <p>Findings include:</p> <p>1. The record for Resident #12 was reviewed on 1/8/15 at 12:09 p.m. Diagnoses included, but were not limited to, diabetes, renal insufficiency, hypertension, and chronic obstructive pulmonary disease.</p>	R 0216	<p><b>R0216 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> A self-administration assessment was performed for resident #12 on 1/26/15 Physician order obtained for resident # 12 to perform independent blood sugar checks on 1/26/15 Service plan for resident #33 was updated with current interventions related to resident falls on 8/1/14 and 9/12/14. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents with falls or those who perform blood sugar check independently have the potential to be affected. <b>III The facility will put into place the following systematic changes to ensure</b></p>	02/07/2015

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	<p>The resident's record lacked a self administration assessment and a Physician order to administer his own accuchecks.</p> <p>During an interview on 1/8/15 at 1:00 p.m., LPN #1 indicated the resident should have had a self administration assessment completed and he should have had an order to administer his own accuchecks. 2. On 1/8/15 at 10:00 a.m., the record review for Resident #33 was completed. Diagnoses included, but were not limited to, osteoarthritis, depression, high blood pressure, and Congestive Heart Failure.</p> <p>The resident moved in her current apartment on 5/20/13.</p> <p>The nurse's notes indicated the resident had falls on 8/1/14 and 9/12/14.</p> <p>The most current service plan dated 11/10/14 had no documentation concerning falls.</p> <p>On 1/8/15 at 2:30 p.m., LPN #1 indicated the resident should have had this information on her service plans.</p>		<p><b>that the deficient practice does not recur.</b> Residential Unit Manager has been re-educated to initiate or update service plans post fall with interventions. Residential self- administration assessment was revised to include evaluation of residents ability to perform own blood sugar check. Residential licensed nurses were re-educated on the completion of self-administration assessment to include performing blood sugars independently. Residential licensed nurses were educated on obtaining physician order for resident to perform independent care procedures including blood sugar checks. Residents with falls reviewed and service plan initiated/updated as needed with current interventions. Self-administration assessments have been re-done on residents who perform independent blood sugar checks. Physician orders have been obtained for residents performing independent blood sugar checks.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b> DON or designee will audit clinical records of residents who fall 5 days a week for 4 weeks, weekly for 4 weeks, monthly for 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. AL</p>		

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R 0217  Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be		unit manager or designee will audit self-administration assessments and physician orders for independent care procedures upon admission, bi-annually, and with changes related to independent care procedures. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. <b>V. Plan of Correction completion date.</b>  Plan of Completion date February 7, 2015	

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	<p>signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure the service plans were updated for services performed and were completed for 5 of 5 residents reviewed for service plans. (Residents #12, #41, #32, #33 and #9)</p> <p>Findings include:</p> <p>1. The record for Resident #12 was reviewed on 1/8/15 at 12:09 p.m. Diagnoses included, but were not limited to, diabetes, renal insufficiency, hypertension, and chronic obstructive pulmonary disease.</p> <p>On 1/2/15 at 10:00 a.m., information was requested for residents who self administered their own medications and those who required accuchecks performed. Information was provided on 1/2/15 at 3:00 p.m., which indicated this resident had a special care need and performed his own accuchecks.</p>	R 0217	<p><b>R0217</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>The service plan for resident #12 was updated to reflect the self-administration of accuchecks.</p> <p>The service plan for resident #41 was updated to reflect the current services received.</p> <p>The service plan for resident #39 was updated to reflect the current</p>	02/07/2015

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	<p>The resident's semi-annual Service plan dated 8/27/14, lacked documentation the resident performed his own accuchecks or he was a diabetic.</p> <p>During an interview on 1/8/15 at 1:00 p.m., LPN #1 indicated the self administration of the accucheck performed by the resident, the diagnosis of diabetes and the care he received for his diabetes should have been added to his service plan. She indicated his service plan was not updated with his current services that he received.</p> <p>2. The record for Resident #41 was reviewed on 1/8/15 at 1:10 p.m. Diagnoses included, but were not limited to, dementia, suprapubic catheterization, deafness and atrial fibrillation.</p> <p>The resident's six-month service plan dated 11/12/14, lacked documentation of the resident's suprapubic catheter care being completed by Home Health Care nurses and himself, he had deafness and the required care for the deafness and he had dementia. The service plan indicated under "Hygiene" for the goal "Res [resident] will maintain good skin integrity with no issues off [sic] break down, to be CDI [clean, dry, intact]. Maintain good oral hygiene, and hair care</p>		<p>services received.</p> <p>The service plan for resident #9 was initiated to reflect the current services received.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>All residents have the potential to be affected.</p> <p><b>III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>All service plans were reviewed and updated with current services received, and signatures obtained by resident or POA as warranted.</p>	

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	<p>to be kept." The action plan indicated, "Resident will perform self care as long as able Family to complete Supra pubic Cath Care." The "Mobility" area indicated for the goal "Resident will ambulate safely And use of power chair." The action plan indicated, "Staff will monitor residents gait as well as use of power chair." The "Mental Status" area lacked information.</p> <p>The resident's Physician recapitulation dated January 2015, included, but were not limited to the following orders: 2/13/14--Clean the resident's supra pubic catheter site once daily with soap and water, pat dry by the resident and Home health care nurse on dayshift. 2/13/14--Change the resident's suprapubic catheter monthly with a 20 french/10 milliliter balloon catheter by a Home Health Care nurse.</p> <p>During an interview on 1/8/15 at 2:12 p.m., LPN #1 indicated the resident's family did not do the resident's Suprapubic catheter care. She indicated that Home Health Care (HHC) comes in and provides care to the resident for his catheter and the resident emptied and changed the bag when HHC was not in the facility. She indicated he wore hearing aides and he heard better out of his left ear. She indicated he used a</p>		<p>Licensed nursing staff was reeducated about initiating service plans at admission, and updating service plans with current services received.</p> <p>AL UM has been re-educated about reviewing service plans biannually and obtaining signatures of resident or POA with staff present at review.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON or designee will audit a random selection of service plans weekly x 8 weeks and monthly x 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be</p>	

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	<p>walker for ambulation and a power chair for locomotion. She indicated his service plan was not updated with his current services that he received. 3. Resident # 39's record was reviewed on 1/8/2015 at 12:05 p.m. Diagnoses included, but were not limited to, Parkinson's, atrial fibrillation, dyspnea (trouble breathing) and edema (swelling).</p> <p>Resident's service plans signed but not dated were provided by the facility on 1/8/2015 at 1:35 p.m. One of the resident's service plans provided indicated only one signature of a staff member was on the service plan, and no date was available to indicate when this was done. No other signatures were on the service plan.</p> <p>The second service plan was signed but no date was found to indicate when the service plan was written, and it was the same as the first service plan. No updates or differences to indicate if this was to be an updated service plan.</p> <p>The record indicated there were discrepancies in the service plan and nurse's progress notes. The service plans indicated for continence, "...Goal Resident to remain continent / manage incontinent in proper manner Action Plan managed per resident to remain</p>		<p>responsible for ensuring compliance.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is February 7, 2015</p>		

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	<p>independent as long as able with staff assist of colostomy[an opening -- called a stoma - that connects the colon to the surface of the abdomen creating a new path for waste]...." The nurse's progress notes indicated on 1/7/15, "...with [name of home health service] to set up education for this res[resident] to change ileostomy[an opening from the ileum -- last portion of small intestine] successfully per self...."</p> <p>The service plans for this resident were incomplete with nothing written for significant areas of care including, but not limited to, telephone use, shopping, laundry, transportation, financial management, well being, mental status and history of falls.</p> <p>4. On 1/8/15 at 11:30 a.m., the record review for Resident #9 was completed. Diagnoses included, but were not limited to, diabetes, depression, menierres disease, and history of right fib fracture.</p> <p>The resident was admitted on 11/3/14.</p> <p>There was no documentation of a service plan found.</p> <p>On 1/8/15 at 2:35 p.m., LPN #1 indicated there was no service plan in the resident record.</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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