STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included the State Residential Licensure Survey. Survey dates: August 3, 4, 5, 6, 7, 8, 2014 Facility number: 012523 Provider number: 155789 AIM number: 201027870 Survey team: Julie Dover, RN, TC Rita Bittner, RN Tammy Forthofer, RN Angela Halcomb, RN Census bed type: SNF/NF: 63 Residential: 58 Total: 121 Census payor type: Medicare: 21 Medicaid: 24 Other: 76 Total: 121 Residential sample: 7 These deficiencies reflect state findings	F000000	This plan of correction is prepared and executed because it is required by the provision of the State and Federal la and not because RidgeWood Health Campus agrees with the allegations and citations. RidgeWood Health Campus maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance.	

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

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

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	cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on August 18, 2014, by Brenda Meredith, R.N.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically			

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	update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review, interview and observations, the facility failed to ensure the physician was notified in regard to a change of behavior and weight loss, for 2 or 3 resident issues reviewed for notification. (Resident #4) Finding includes: 1. Resident #4's record was reviewed on 8/7/2014 9:38 a.m. The Minimum Data Set (MDS) Admissions, dated 6/11/14, indicated Resident #4 had a Cognitive score 07, sever impairment. The Behavioral Symptoms directed toward was others 1 (1-3 days), Verbal behavioral symptoms directed toward others 1 in 1 to 3 days. The Behavior Care Plan, dated 6/9/2014, indicated to Notify MD [physician] of any adverse side effects. The Nurse's Progress Note, dated 7/28/2014 at 12:30 p.m., indicated: "Resident came at nurse and grabbed my inner thigh. I explained to resident to not do that, resident then went and grabbed at my B---. I again explained to resident that is not appropriate. Resident then removed from area and put in front of	F000157	Resident #4 - NP/MD were notified of increase and change in behavior on 8/8/2014 by the licensed nurse; order was obtained for resident to be admitted for further evaluation. Resident #4 was discharged on 8/8/2014 therefore further corrections on this deficiency could not be completed. Resident #24 was interviewed by Social Services and verified that Resident # 4 had not re-entered his room as of 8/8/2014 and he was happy with his room. All residents with behaviors were reviewed by DHS and Social Services to verify physician was fully aware of any behaviors. All resident weights were reviewed by ADHS and verified that MD's were aware of all significant weight losses on 9/4/2014 during the clinically at risk meeting. DHS/ADHS will inservice nurses on the importance of notifying MD of changes in behavior and/or weight changes when indicated using the Guidelines for Physician Notification. DHS/ADHS will audit behavior forms for proper MD notification weekly x 4 and these will be reviewed in the weekly clincially at risk meeting. DHS/ADHS will audit weight changes for proper MD notification when indicated weekly x 4; 2x per month x3 months; and 1x monthly x3 and these will be	09/04/2014

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	Television. Resident then started following this visitor down hall chasing and grabbing at visitor." The Nurse's Progress Note, dated 8/1/2014 at 6:00 p.m., indicated: Resident has had several incidents of attempting to grab female employees, including Nurse Practitioner. Resident has also attempted to wonder into several other residents rooms and has required constant redirection for both behaviors. During an interview on 8/5/14 at 2:57 p.m., LPN #2 indicated Resident #4 has moods of behavior issues and goes into other residents rooms. She indicated to prevent him from entering other residents room, she tries to shut the other residents' doors when he is having a bad day. During an interview on 8/6/14 at 10:34 a.m., LPN #1 indicated resident #4 chased her around the hall on 7/31/14 at 12:30 and 1:00 p.m., The resident's behavior has effected how she does her job. LPN #4 indicated she has to take an aid into the room to give Resident #4 his medication due to his behavior. During an interview on 8/6/14 at 11:12 a.m., the DON [Director of Nursing] indicated the resident only does this behavior with the staff whom are young		reviewed in the weekly clinically at risk meeting. The results of audits will be presented to the QA committee and the need for continued audits will be determined.	

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	girls. She is aware that the things the facility are doing are not working. The DON was not aware of Resident #4 going into other residents room. She indicated the policy for behavior issues is; for staff to document the incidents, then social services will follow up on incidents. Social Services will request a referral for psych evaluation if necessary. During an interview 8/6/14 at 11:30 a.m., the Social Service Director indicated there is no pattern of behaviors for Resident #4 and they only occur with staff. She has talked to staff concerning his behavior in public and has advised them to not draw attentions to those behaviors. During an interview 8/6/14 at 12:21 p.m., CNA #9 indicated resident #4 has been removed from the dining room due to his behavior of grabbing staff. Resident #4 did not take a bite of his meal prior being removed from the dining room. During a phone interview on 8/7/2014 at 9:14 a.m., the Psychiatric Mental Health Nurses Practitioner (PMHNP) #13 indicated Resident #4 requires more supervision then currently offered. Resident #4 did not show symptoms of improper behavior with the increased number of staff at the psych unit.			

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	PMHNP indicated she was not aware of the resident going into other residents rooms. During an interview on 8/7/2014 at 9:29 a.m., Resident #24 indicated Resident #4 has been in his room un-invited and he has had to call a nurse to remove the resident. During an observation on 8/6/14 at 12:26 p.m., Resident #4 went into the entrance Resident #3's room with his wheeled chair. After rolling four feet into the room, resident #4 looked around and rolled his wheel chair back out into the sitting area. 2. The clinical record for Resident #4 was reviewed on 8/7/14 at 9:38 a.m. The Nutritional Assessment and Data Collection sheet indicated Resident 4's weights were as follows: - 6/04/14, 198 pounds - 6/22/14, 193 pounds - 6/29/14, 191.6 pounds - 7/06/14, 189 pounds The Care Plan, dated 6/9/2014, indicated under Heights/Weights: The goal for weight was to remain stable. The interventions included Resident #4 was to be weighted weekly to monitor for changes. Meals/Snacks/Fluids care plan			

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	indicated Resident #4 was on regular diet and the goal was to have an adequate consumption of meals. The Interventions included staff were to monitor intake. During an interview 8/6/14 at 12:21 p.m., CNA #9 indicated resident #4 has been removed from the dining room due to his behavior of grabbing staff. Resident #4 did not take a bite of his meal prior being removed from the dining room. During an interview on 8/6/14 at 2:01 p.m., CNA # 15 indicated Resident #4 consumed 50% of lunch and refused substitute offered. During an interview on 8/7/2014 at 12:45 p.m., LPN #8 indicated after a weight loss of 5 lbs the nurse must notify physician. During an observation on 8/6/14 at 12:21 p.m., Resident #4 was sitting on the left side of the dinning room by the main entrance. Resident #4's meal was sitting on the other side of the room. The resident's plate was full of food. The drinks were sitting on the table full. Resident #4 was wheeled by CNA #9 into the sitting area by the nurses station on the Dearborn Hall. 3.1-5(a)(3)			

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure a resident's right to for more than 2 showers a week according to the resident's preference for 2 of 9 residents reviewed for preferences. (Resident #53 and Resident #130) Findings include: 1. During an interview on 8/4/14 at 3:20 p.m., Resident #53 indicated he advised Licensed Practical Nurse (LPN) #8 two weeks ago that he would like to take three showers a week instead of two. The clinical record for Resident #53 was reviewed on 8/6/14 at 9:35 a.m.	F000242	Nursing staff were immediately inserviced on resident #53's preference for showers 3 times per week. Resident #53's care plan was immediately updated to reflect desire for showers 3 times per week. Resident #130 discharged to home safely on 8/26/2014. All residents shower preferences were reviewed with the residents by the Life Enrichment Director to verify preferences were honored. ED inserviced Life Enrichment Director regarding importance of obtaining shower frequency preferences when completing the Resident Preferences and Activities Profile and updating resident care plan with shower frequency preferences. ED/LED	09/04/2014

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	Resident #53 bathing schedule was Wednesday and Saturday evening. The Minimum data Set (MDS) Quarterly assessment, dated 4/18/14, indicated the resident had a Cognitive score of 15, no cognitive impairment. No care planing was noted for resident's choices of bathing schedule on the Care Plan for Activities of Daily Living dated 7/18/14. Nursing documentation did not indicate a request for increase in bathing days from 2 to 3. During an interview on 8/6/14 at 11:09 a.m., the Director of Nursing (DON) indicated residents can have more then two showers a week. The nurse is to talk to the Certified Nursing Assistant (CNA) and initiate the change in schedule. If there is a problem with the schedule then the staff or resident is suppose to talk with her directly and she will change the schedule. During an interview on 8/6/14 at 2:01 p.m.,LPN #1 indicated when a resident advises the CNA or the nurse concerning a request for choices the nurse is to document request in the nursing notes. During an interview on 8/7/2014 at 9:36 a.m., LPN #8 indicated she spoke with		will audit new admissions to ensure shower frequency preferences are obtained and added to the resident's care plan weekly x 4; 2x per month x3 months; and 1x monthly x3 . The results of the audit will be presented to the QA committee and the need for continued audits will be determined.	

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	Social Services concerning Resident #53 shower change request in the past. She was unsure of the date and did not document the request in the resident's chart. 2. During an interview, on 08/04/2014 at 11:12 a.m., Resident #130 indicated he only gets a shower twice a week. He indicated staff was made aware when he first got here and was told he was going to get showers twice a week that it was not enough. During an interview, on 08/06/2014 at 2:28 p.m., the Social Service Director indicated she is the person residents talk to about their choices upon admission. She provided no record of Resident #130's choices upon admission. During an interview, on 08/06/2014 at 3:00 p.m., with the Customer Service Specialist, she provided a copy of the admission packet which included residents rights to choose activities, schedules, and care consistent with resident's interests, assessments, and plan of care. During an interview, on 08/06/2014 at 3:14 p.m., the Social Services Director indicated the Activities Director usually goes over preferences with the resident on admission. Record review of the			

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	"Resident Preferences and Activities Profile" indicates it is very important for Resident #130 to choose between a shower, tub, or bed bath, but does not address the issue of how often the resident would like to shower. During an interview, on 08/06/2014 at 3:25 p.m., with the Activities director, she indicated resident's choices are documented within 5 days of admission, she tries to do them within the first 24 hours on Resident activity Profile, then she enters the resident's preferences into the care plan. Review of the Care Plan, on 08/06/2014 at 3:51 p.m., shows no indication of resident's preferences to shower daily. Review of the Nurse Notes indicated resident's request for a shower on 06/30/2014. No other notes indicating resident's request for showers daily were noted. During an interview, on 08/08/2014 at 9:09 a.m., with Certified Resident Care Assistant #22, she indicated resident received a shower last night at 8:30 p.m. She indicated that was the time he likes to get his showers. Resident is scheduled to get showers on Mondays and Thursdays only.			

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	3.1-3(u)(1)			
F000247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to notify two of three residents reviewed for room change notification.(Residents #24, Resident # 63) Findings include: On 8/7/2014 at 2:45 p.m., the clinical record for Resident #63 was reviewed. Resident # 63 moved from one room to another on Tanner Trace. There was no notification in the record to indicate Resident #63 had been given notice of the room change. On 8/7/21014 at 2:45 p.m., the clinical record for Resident #24 was reviewed. There were no notifications in the chart to indicate a notification of a room change had been given to the resident or the resident's family. On 8/7/2014 at 3:10 p.m., during an interview LPN #8 indicated Resident #24 had moved from Wilson Way to Assisted Living.	F000247	ED inserviced Social Service Director of importance of documenting room change notifications in resident chart per the resident right to receive notice before the resident's room or roomate in the facility changes. Resident #24 and Resident #63's charts were updated to reflect notification of room change. ED audited resident records whom had room changes for proper room change notification documented in resident chart. ED in conjuction with Social Services Director will audit resident chart for room changes to ensure proper documentation is present weekly x 4; 2x per month x3 months; and 1x monthly x3 . The results of the audit will be presented to the QA committee and the determination for continued audits will be determined.	09/04/2014

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	On 8/7/2014 at 3:30 p.m., the Director of Resident Services (DRS) indicated she talks to the resident moving rooms and talks to the new roommate. She also indicated she talks to the residents family to notify them of the room change. She further indicated she usually puts a note in the residents clinical chart under the social service tab indicating the room change. The DRS indicated the admissions department takes care of moving the residents from the assisted living area to the health care center. The DRS indicated she sets up a care plan meeting with the family either in person or by phone to talk about the residents decline and need to move to the health care center then the admissions department will assign a room number. This meeting is documented on a "residents first" care plan note. The DRS indicated anyone who moves rooms in the facility should have a social service note in their chart unless the move is temporary for isolation purposes. 3.1-3(v)(2)			
F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and			

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	periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, record review and interview, the facility failed to conduct an accurate dental assessment as part of the MDS (Minimum Data Set) assessment for 1 of 1 residents reviewed for Oral/Dental Status. (Resident #72)	F000272	MDS coordinator will modify resident #72's Quarterly MDS assessment to reflect accurate condition of oral/dental status. Current MDS assessments will be reviewed to ensure accurate capture of oral/dental status and modifications will be completed	09/04/2014

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	Finding includes: During an observation, on 8/4/2014 at 9:00 a.m., Resident #72 was observed to have several missing teeth on the bottom portion of her mouth. The clinical record for Resident #72 was reviewed on 8/5/2014 at 2:35 p.m. The diagnoses included, but were not limited to hyperlipidemia, dementia, and depression. Resident #72's chart lacked documentation of dental services being provided by the facility dentist or a private dentist. A monthly nursing assessment and data collection document, dated 2/15/2014, under the nutrition section, indicated the resident had obvious or likely cavity or broken natural teeth. A Speech Therapy Plan of Care, dated 2/18/2014, indicated underlying impairment: Swallowing and Dentition: Resident has missing teeth. The Quarterly MDS (Minimum Data Set) assessment, dated 6/11/14, did not indicate, on the Oral/Dental Status section, the resident had "Obvious or likely cavity or broken natural teeth...." A monthly nursing assessment and data		as indicated. DHS inserviced MDS coordinators regarding importance of capturing accurate condition of resident oral/dental status. DHS/MDS coordinator will audit 3 Quarterly MDS assessments per week x 4 weeks to ensure accurate condition of oral/dental status is captured on the Oral/Dental Status section of the Quarterly MDS assessment. Results of the audit will be presented to the QA committee and the need for continued audits will be determined.	

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	collection document, dated 7/16/2014, under the nutrition section, did not indicate the resident had obvious or likely cavity or broken natural teeth. During an interview, on 8/6/2014 at 10:18 a.m., the MDS coordinator indicated when doing my assessments I go and assess the resident's and I also review the nurses notes and documents that are in the chart. During an interview, on 8/7/2014 at 10:56 a.m., LPN #21 indicated that Resident #72 was being seen by [dental company] prior to becoming a hospice patient. LPN #21 reviewed Resident #72's chart and indicated there was no documentation in the chart that [dental company] had seen the patient. 3.1-31(c)(9)			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be			

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	developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to involve the resident and or family in the care conferences for 1 of 1 resident's reviewed for care conferences. (Resident #70) Finding includes: The clinical record for Resident #70 was reviewed on 8/6/2014 at 9:08 a.m. The diagnoses included, but were not limited to heart failure, hyperlipidemia, Alzheimer's disease, dementia, anxiety disorder and depression. Resident #70's chart lacked documentation of care conference information, or POA (Power of Attorney) having been contacted or invited to the care conferences. During a phone conference on 8/4/2014 at 1:35 p.m. Resident #70's daughter, indicated that she has never been invited to attend a care conference meeting for her father.	F000280	A care conference was held via telephone for resident # 70. All resident's care conference dates were reviewed by LND. Any care conferences requiring to be scheduled were set up by the LND. Letters were sent by LND to five families as they were unable to be reached by phone to schedule a care conference. ED inserviced Legacy Neighborhood Director regarding importance of involving the resident and/or family in a care conference in an appropriate time frame per resident right requirements to participate in planning care and treatment. ED/Legacy Neighborhood Director will audit new admissions to ensure care conference involving resident and/or family is scheduled with in appropriate time frame weekly x 4; 2x per month x3 months; and 1x monthly x3 . Results of the audit will be presented to the QA committee and the need for further audits will be determined.	09/04/2014

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	During an interview on 8/6/2014 at 2:25 p.m. LPN #21 indicated I call the families to set up the care conference meetings. LPN #21 indicated she took over the position on Legacy in April 2014 and indicated there is no documentation in Resident #70's chart in the Social Services section indicating that a care conferences has been done. During an interview on 8/6/2014 at 2:54 p.m. The SSD (Social Service Director) indicated that she was doing some of the care conferences at Legacy during the 3 to 4 months when they did not have coverage in Legacy. SSD indicated I did not do a care conference for Resident #70. 3.1-35(c)(2)(C)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to implement care plan interventions related to weights (Resident #129), fluid intake (Residents #130 and #125) and toileting	F000282	Resident #125's intake and toileting records were reviewed by the DHS. Care plan intake and toileting interventions for resident #125 were reviewed with nursing staff by the DHS. Resident	09/04/2014

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	interventions (Resident #125) for 3 of 3 residents reviewed for care plans. Findings include: 1. The clinical record for Resident #129 was reviewed on 8/6/2014 at 12:12 p.m. The diagnoses included, but were not limited to, edema. Resident #129 was admitted to the facility on 6/26/2014. A telephone order, dated 6/27/2014, indicated to weight Resident #129 twice a week. Physician orders, dated 7/1/2014 through 7/31/2014, indicated Resident #129 was receiving lasix 80 mg (milligrams) (a diuretic) and spironolactone 25 mg. (a diuretic). The MDS (Minimum Data Set) admission assessment, dated 7/3/2014, under height/weight, indicated the resident's admission weight was 241 lbs (pounds). Resident #129's height/weight care plan indicated, "I have a history of weight fluctuation because I have a history of edema. I receive a water pill to help promote my fluid balance. My doctor would like me weighted twice a week, please ensure this is being done and my		#125's intake/meals will be monitored weekly in the clinically at risk meeting by DHS/ADHS. Resident #125's toileting report will be audited by the DHS/ADHS weekly x 4; 2x per month x3 months; and 1x monthly x3 . Remaining residents meal intakes, toileting and weight records were reviewed by DHS/MDS coordinators in the clinically at risk meeting. Any identified issues were addressed by the DHS as indicated. 1. Resident #129 safely discharged home on July 18th, 2014. DHS/ADHS will inservice nursing staff on importance of following residents care plan interventions related to weights using current facility policy for following resident plan of care. DHS/ADHS will audit 4 residents with weight interventions to ensure they are being followed as ordered weekly x 4; 2x per month x3 months; and 1x monthly x3. The results of the audit will be presented to the QA committee and the need for continued audits will be determined. 2. & 4. Resident #130 safely discharged home on 8/26/2014. DHS inserviced nursing team members regarding following fluid and/or food intake interventions on resident care plan using current facility policy for following resident plan of care. DHS/ADHS will audit 3 residents with fluid and/or food intake interventions to ensure interventions are being followed	

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	doctor is notified with any concerns." On 8/7/2014 at 12:20 p.m. The DON (Director of Nursing) presented July weight for Resident #129. The weight was 259 pounds. During an Interview on 8/7/2014 at 2:50 p.m. The DON indicated this is the only weight we have for Resident #129. 2. During an interview, on 08/04/2014 at 2:18 p.m., Resident #130 indicated his water jug sits all day without being refilled unless he asks for it to be refilled. During an interview on 8/6/14 at 2:01 p.m., the DON indicated the CRCA'S (Certified Resident Care Associate) are given a job description during their interview and during onboarding. A copy of the job description was provided by the payroll coordinator in the business office. The job description for the Certified Resident Care Associate lists, under Food Service Functions, indicated "Keep residents' water pitchers clean and filled with fresh water (on each shift), and within easy reach of the resident." During an interview, on 08/06/2014 at 2:18 p.m. Resident #130 indicated his wife refilled his water pitcher last night		as indicatedweekly x 4; 2x per month x3 months; and 1x monthly x3. The results of the audit will be presented to the QA committee and the need for continued audits will be determined. 3. DHS/ADHS will inservice nursing staff on importance of following residents care plan for toileting needs and need to document when assisting a resident with toileting using current facility policy for following resident plan of care. DHS/ADHS will audit through observation and/or documentation 3 residents with interventions regarding toileting on care plan to ensure plan of care is being followed as indicated weekly x 4; 2x per month x3 months; and 1x monthly x3 . The results of the audit will be presented to the QA committee and the need for ongoing audits will be determined.	

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	with fresh water as she has done every night she visited, and the pitcher has not been refilled since. During an interview, on 08/06/2014 at 2:26 p.m., the second shift nurse on Wilson Way hall, RN #23 indicated the CRCA's refill the water pitchers after the change of shift or sometimes at suppertime. During an interview, on 08/07/2014 at 10:22 a.m. CRCA #14, indicated they do it whenever they get the chance. During an interview, on 08/07/2014 at 12:55 p.m., Resident #130 indicated his water pitcher was refilled this morning following his request. During an interview, on 08/07/2014 at 4:11 p.m., Resident #130 indicated his water jug had not been refilled that afternoon and he could tell because he had just taken a drink. Resident #103's record was reviewed on 08/08/2014 at 10:38 a.m. The admission MDS (Minimum Data Set) assessment, dated 07/04/2014, indicated a BIMS (Brief Interview of Mental Status) score of 15, indicative of no cognitive impairment. The care plan indicated the resident was on a regular diet with a			

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	history of poor appetite and intake with a goal of improved and adequate consumption of meals. The interventions included to monitor food and fluid intake and encourage fluids with and between meals. The Meal Intake Detail Report for the previous 2 weeks did not contain fluid consumption. 3. Record review for Resident #125 was conducted on 8/05/2014 at 2:36 p.m. The admission MDS assessment, dated 06/12/2014, indicated a BIMS score of 4, cognitive impairment. The Care Plan, dated 07/12/2014, indicated resident needs assistance with toileting and is to be toileted every 2 hours during incontinence checks. The Bowel and Bladder Detail Report indicated, from 06/09/2014 thru 07/13/2014, resident was toileted from 1 to 4 times daily. During an interview, on 08/06/2014 at 4:29 p.m., CRCA #22 indicated resident refused to be toileted at 2:30 p.m. Interviews were conducted on 08/07/2014 at 2:26 p.m. CRC #24 indicated Resident #125 was just toileted and resident was dry with no output. She indicated therapy may have just toileted her. Interview with the Physical Therapy			

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	Program Director, indicated resident had not been in therapy since this morning and was taken back to her hall before lunch. She also indicated the therapy team will toilet a resident if they are the ones getting the resident out of bed in the morning. She contacted Occupational Therapist #25, to see if she had toileted the resident this morning. Occupational therapist #25 indicated the resident was already up in her wheelchair reading her book this morning and therefore, not toileted by her. An interview with RN #26, indicated no residents on Wilson Way Hall are being monitored for intake and output. She also indicated resident #125 sits in the living room on Wilson Way hall or goes to activities during the day where she can be closely monitored. On 08/07/2014 at 2:45 p.m., RN #26 checked with CRCA #22, who indicated she had not received any report on the resident's output today. She indicated she did not get a report sheet from the day shift CRCA indicating how many times the resident's went to the bathroom today. CRCA #22 had worked the night before and filled out a report but could not find it, she indicated she had left it on a clip board for the night shift. The "Bowel and Bladder Detail Report," provided by the Administrator on			

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	08/08/2014 at 9:52 a.m., indicated resident's last report of being toileted was on 08/06/2014 at 3:13 a.m. 4. Record review for Resident #125 was conducted on 8/05/2014 at 2:36 p.m. The admission MDS assessment, dated 06/12/2014, indicated a BIMS score of 4, cognitive impairment. Resident #125 had admitting diagnoses, including but not limited to, hypertension, urinary tract infection, hypocalcemia, arthritis, failure to thrive, and endometrial cancer. On 08/07/2014 at 2:45 p.m., Resident #125 was observed in a wheelchair in the living room on Wilson Way, sitting at the same table she had lunch at. No drink or food was noted on the table. On 08/07/2014 at 3:20 p.m., review of the care plan indicated under the heading "Meals/Snacks/Fluids" the resident was to have her intake of foods and fluids monitored, and encouraged to drink fluids with and in between meals. The intake record indicated resident had a fluid intake of 120 cc (cubic centimeters) for 08/05/2014, no fluid intake was reported for 08/06/2014 or 08/04/2014. No records were noted for food or fluid intake for breakfast or lunch since 07/29/2014.			

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	On 08/07/2014 at 3:53 p.m., the resident was observed sitting in a soft arm chair in the living room of Wilson Way with her feet propped up, sleeping, no drink was noted near the resident. 3.1-35(g)(2)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview the facility failed to ensure that there was documented communication between the dialysis center and the nursing facility to ensure the resident was monitored following dialysis, 1 of 1 residents reviewed. (Resident #57) Finding includes: On 08/06/2014 at 10:21 a.m., RN #6 indicated Resident #57 goes to Dialysis on Monday, Wednesday, and Friday. Resident #57 leaves the facility at 1:00 p.m. and returns between 5:00 p.m. and 6:00 p.m. RN #6 indicated upon the residents return the nursing staff doesn't sign her in or do an assessment. RN #6	F000309	DHS immediately implemented a communication form between RidgeWood Health Campus and the dialysis center for resident #57. DHS/ADHS will inservice nursing staff regarding utilization of the communication form between the campus and the dialysis center using guidelines for dialysis provider communication. DHS/ADHS will audit residents going to dialysis weekly x 4; 2x per month x3 months; and 1x monthly x3 to ensure the communication form for dialysis is being used. The results of the audits will be presented to the QA committee and the need for ongoing audits will be determined.	09/04/2014

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	further indicated the dialysis center will fax papers to the nursing facility at times. On 08/06/2014 at 10:41 a.m., Resident # 57 indicated she didn't like being gone away for so long but understands she needs dialysis. Resident #57 indicated she may be changing to a morning time slot for dialysis. On 08/06/2014 at 10:52 a.m., the clinical chart for Resident #57 was reviewed. The care plan indicated Resident #57 takes a cab services to and from the dialysis center. The care plan also indicated a sack dinner is to be packed for Resident #57 to take with her. On 08/06/2014 at 12:18 p.m., the Director of Health Services (DHS) indicated when Resident #57 returns from the dialysis center the nurses would just observe her. Once a week the dialysis center will fax lab results for Resident #57. Resident #57 is sent to the dialysis center with a face sheet. The DHS further indicated she was not sure what her nursing staff did when a resident returned from dialysis, "I've never checked before." On 8/6/2014 at 2:00 p.m., a copy of the "GUIDELINE FOR DIALYSIS PROVIDER COMMUNICATION" was			

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	reviewed. "...4. A report (may be written or verbal) shall be requested from the Dialysis Provider that will alert the campus regarding: a. tolerance to the procedure, b. vital signs, c. medication administered, d. other information deemed necessary for the ongoing provision of care. 5. Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring of the shunt site for signs of complication, b. Review the Dialysis Provider paperwork for any necessary follow up requirements...." 3.1-37(a)			
F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be			

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	posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post the current staffing sheet for 2 of 2 buildings observed for staffing sheets. (Main building and Legacy) Findings include: During an observation, on August 3, 2014 at 5:40 p.m., the posted staffing sheet on Dearborn Drive nurses station was dated July 29, 2014. During an observation, on August 4, 2014 at 8:55 a.m., there was no staffing sheet posted at the nurses station on the Legacy Unit. During an observation, on August 5, 2014 at 8:30 a.m., the posted staffing sheet on Dearborn Drive nurses station was dated July 29, 2014.	F000356	ED immediately inserviced scheduler regarding necessity of posting current staffing sheets per regulatory requirements. ED/scheduler will daily audit through observation the posting of current staffing sheets weekly x 4; 2x per month x3 months; and 1x monthly x3. The results of the audit will be presented to the QA committee and the need for further audits will be determined.	09/04/2014

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	During an observation, on August 5, 2014 at 9:16 a.m., there was no staffing sheet was posted at the nurses station on the Legacy Unit. During an observation, on August 5, 2014 at 2:28 p.m., there was no staffing sheet was posted at the nurses station on the Legacy Unit. During an interview, on August 5, 2014 at 2:30 p.m., QMA (qualified medication aide) #38 indicated we usually post the staffing sheets daily. I don't know why it is not out. During an observation, on August 6, 2014 at 8:47 a.m., there was no staffing sheet was posted at the nurses station on Dearborn Drive. During an observation, on August 6, 2014 at 9:52 a.m., here was no staffing sheet was posted at the nurses station on the Legacy Unit. During an Interview on August 6, 2014 at 10:24 a.m. The DON (director of nursing) indicated the staffing sheets are suppose to be posted daily in the Main building and Legacy. On August 6, 2014 at 12:39 p.m., the DON provided a copy of the current			

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	policy and procedure for "BIPA Staff Posting." II. "Procedures A. Each campus must post the number of direct care staff (RNs, LPNs, CNAs/STNAs/SRNAs) along with the number of hours worked at the beginning of each shift on a daily basis (for a 24 hour basis).... B. The document must include the campus name, current date, and total number and actual hours worked by category. C. The document must include the census at the beginning of each shift. D. The document should be placed in a prominent place that is readily accessible to residents and visitors...."			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview, and record review the facility failed to store, prepare, and serve food in a sanitary manner in the Main dining room and kitchen, and in the Legacy dining room and kitchen, for 4 of 4 dining observations and 5 of 5 kitchen observations related to hand washing, food storage, and food preparation, affecting 4 out of 4 residents on pureed	F000371	24 hour report was reviewed by DHS to ensure the identified residents #37, #83 and #57 have not exhibited any signs or symptoms of infection. All residents recieving meals had the potential to be affect by the practice. DFS and ADFS were re-educated by Divisional Dietary Support on 8/7/2014 on following proper procedure for storing, preparing and serving food in a	09/04/2014

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	diets, and residents served in The Main and Legacy dining rooms. Findings include: 1. During the initial tour of the main kitchen on 08/03/2014, at 5:20 p.m., Dietary Aide #28 held part of a loaf of bread up to his shirt, then wrapped the bread with plastic wrap. The walk-in refrigerator contained a bag of coleslaw with a "best used by" date of 07/26/14, an uncovered whole pie, and two opened bags of pepperoni without dates. During inspection of the walk- in freezer, it was noted to have four large boxes of unopened, frozen bread less than the required 18 inches from the ceiling, and three boxes of unopened, frozen bread on the floor of the freezer. During an observation, on 08/03/2014 at 5:45 p.m., of the kitchen in the Legacy building, Dietary Aide #30 spilled 4 wheat rolls out of a bag into a bowl containing 3 other bags of bread. He picked up the rolls with his bare hands and put them back into the bag. No open dates were noted on 4 bags of bread, 2 opened cartons of instant potatoes, one bottle of olive oil and no open date or expiration date on a two thirds empty bottle of red food coloring. Paper cups, used as scoops, were left in a container of		sanitary environment. DFS/ADFS will inservice food service staff on proper food storage and food preparation per facility's current policy. DFS/ADFS will audit kitchen for proper food storage and food preparation through observation weekly x 4; 2x per month x3 months; and 1x monthly x3. The results of the audit will be presented to the QA committee and the need for continued audits will be determined. DHS/ADHS will inservice staff regarding proper hand washing techniques during meal service per facility guidelines for proper hand washing. DHS/ADHS will audit through observation 3 meal services per week x 4; 2x per month x3 months; and 1x monthly x3 to ensure proper hand washing techniques. The results of the audit will be presented to the QA committee and the need for continued audits will be determined.	

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	flour and a container of powdered sugar. One opened garbage can was noted with no lid in the immediate area. New boxes of juice and a dried puddle of fluid were noted on a shelf below the juice dispenser. The deep fryer contained a food particle 1/2" long and the size of a pencil in it during a time when the fryer was not in use. The covers on top of the fryers were covered with grease. Crumbs were noted on the bottom area of the standing freezer and refrigerator. During an observation of the main dining room on 08/04/2014 at 11:30 a.m. CRCA (Certified Resident Care Associate) #17, washed her hands for 8 seconds then served Resident #87 a slice of Boston Cream pie. The Director of Food Services washed his hands for 10 seconds, put on gloves, then continued to serve food from the steam table. CRCA #17 sorted through resident menus, washed her hands for 6 seconds, then went into the kitchen. The Director of Food Services took off his gloves, washed his hands for 12 seconds, touched the front of his jacket, went into the kitchen, came back out of the kitchen, put on gloves, and continued to serve food from the steam table. During an observation, on 08/06/2014 at 11:10 a.m., of the main kitchen, the paper			

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	towel dispenser above the hand washing sink was empty with two new packages of paper towels stacked on top of it. Dietary aide #31, with gloved hands, got his keys out of his pocket, dropped them on the floor, picked them up, unlocked the paper towel dispenser, and reloaded the dispenser with the 2 packages of paper towels. He then locked the dispenser, took his gloves off, threw them away, and put on new gloves. No hand washing was noted. Dietary aide #32 placed vegetable condiments on a hamburger with her gloved right hand, then placed the bun top on with her bare left hand. Dietary aide #37 washed her hands for 20 seconds, dried them, opened the trash can with her bare hand to throw away her paper towel, put gloves on, and fixed 4 pureed plates with chipped beef, peas, and beets. Crumbs and splatters were noted on the top and bottom of the plate warmer/dispenser and on the bottom shelf of the food prep table where the cutting boards, food trays, and bottles of oil were stored. During an observation, on 08/07/2014 at 10:55 a.m., of the kitchen in the Legacy building, crumbs and splatters were noted on the lower shelf of the food prep table where cutting boards, syrup, pancake mix, oil and plastic wrap were stored. A			

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	pool of liquid with crumbs in it was noted on an inverted muffin tin located on the bottom shelf of a clean dish rack. During an observation, on 08/07/2014 at 11:14 a.m., of the main kitchen, 6 boxes of frozen bread/buns were less than the required 18 inches from the ceiling of the freezer, crumbs and splatters were noted on the bottom shelf of 3 prep tables, the top and bottom of the plate warmer/dispenser, the bottom shelf of the steamer, the bottom shelf of the grill, and the prep table containing the microwave. The top of the ice cream cooler had dark brown streaks across it. A black, clean dish cart with 3 shelves had crumbs on every shelf. Review of the Hand Washing Policy and Storage Procedures, provided by the Administrator on 08/08/2014 at 9:57 and 9:52 a.m., indicated employees are to wash hands for a minimum of 20 seconds, and use a paper towel to lift garbage can lids. Open packages are to be labeled, dated, and stored in closed containers. Scoops for bulk foods are to be stored separately in a covered, protected area. 2. During initial dining observation on 8/4/2014 at 11:43 a.m. CRCA (certified residential care associate) #17 was observed to wash her hands for 5 seconds			

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	and turn the water off with her left hand, then touched Resident #37's shoulder. CRCA #17 washed her hands for 10 seconds and turned the water off with her left hand. CRCA was observed to deliver Resident #3's plate of food. CRCA #17 was observed to wash hands for 10 seconds and turn the water off with her left hand. CRCA #17 removed dirty dishes from the table, entered the kitchen with the dirty dishes, exited the kitchen, washed hands for 13 seconds and turned the water off with her left hand. CRCA #17 was observed to pour coffee for Resident #3. During a second dining observation on 8/6/2014 at 11:27 a.m. The DPO (Director of Plant Operations) was observed to wash hands for 13 seconds and then turned the water off with his left hand. DPO #10 was observed to deliver Resident #83's plate of food. DPO #10 was observed to wash hands for 8 seconds, turned the water off with his left hand and then started flipping through the meal tickets. DPO #10 was observed to remove a pen from his shirt pocket, wrote on the meal tickets placed the pen back in his shirt pocket. DPO #10 washed hands for 14 seconds, turned the water off with his left hand and was			

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	observed to deliver Resident #88's plate of food. DPO #10 was observed to enter the kitchen, exited with kitchen with a glass of milk. DPO #10 delivered the milk to Resident #55, no hand washing or hand sanitizer was observed. CRCA #9 was observed to wash hands for 10 seconds and then delivered Resident #57's plate of food. DPO #10 was observed to wash hands for 7 seconds, turned the water off with his left hand and then delivered Resident #68's plate of food. 3. During an observation on 8/6/14 at 12:01 p.m., Qualified Medication Aide (QMA) #39 picked up two pieces of paper off the floor that fell from the medication cart. She then placed the paper into the garbage container on her cart. After throwing the paper away she used hand gel prior pulling a tray out of the food cart. QMA #39 then delivered resident #90's tray and removed the covers on her drink and positioning the silverware for the resident to use. During an interview on 8/6/14 at 12:09 p.m., QMA #39 indicated the policy of hand washing is to use soap and water after picking something off of the floor.			

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	3.1-21(i)(2)			
F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on interview, observation and record review, the facility failed to ensure disposal of expired medications, medication storage and expired or discharged resident's medication removal, for 7 of 10 observed (Medication storage rooms 3 of 3, Medication carts 2 of 4 and Treatment carts 2 of 3) Findings include: On 8/6/14 at 10:48 a.m., observation was conducted of the Dearborn treatment cart, medication cart and medication room with LPN #1. The following was observed in the treatment cart: Open Ketoconazole topical cream with no open date for Resident #55. Open Double Antibiotic tube for Resident #59 with no open date. Open bottle of Nitro powder with no open date for Resident #53. The following was observed in the treatment room refrigerator: An open vial of Tuberculin solution with no open date. On 8/6/2014 at 3:09 p.m., observation was conducted with RN #7 of the Tanner Hall. Medication cart B had an open container of pudding on top of the cart. The pudding container foil was wide open. Observation of Medication cart A contained an open bottle of Restasis for Resident #66 with no open date.	F000431	DHS/ADHS audited all medication carts, medication storage rooms and treatment carts to ensure proper medication storage.The consulting pharmacy will continue to conduct quarterly medication storage audits. The last audit was conducted on 9/10/2014. DHS/ADHS will inservice nursing staff regarding disposal of expired medications, medication storage, removal of expired and/or discharged residents medications using the facility policy for medicaiton storage in the facility and the facility policy for date marking. DHS/ADHS will audit medication storage rooms, medication carts and treatment carts for expired medications, proper medication storage and removal of expired and/or discharged residents medications as indicated weekly x 4; 2x per month x3 months; and 1x monthly x3. The audits will be presented to the QA committee and the need for ongoing audits will be determined.	09/04/2014

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	On 8/6/2014 at 3:15 p.m., the Tanner Hall medication room was observed with RN #7. The following was observed in the treatment cart : -Open Hydrocortisone tube for Resident #87 with no open date. -Open tube of Mupirocin topical for Resident # 32 with no open date. -Open tube of Ammonium Lactate topical for Resident #44 with no open date. -Open Iodine Bottle for Resident #39 with no open date. -Open tube of Lotrizone Ointment for Resident #66 with no open dates on 2 of 3 small tubes. Observation of the medication room refrigerator contained a bottle of ketchup, Miracle whip, several bottles of orange Gatorade in a plastic bag and 3 cans of Shasta soda. Sitting on top of the refrigerator was a bottle of honey. Sitting on the counter was a bottle of urine dip sticks with an expiration date of 5/2014. The box containing the residents insulin was in the medication room, inside the box was a partially used vial of Lantus for Resident #54 with no open date. Resident #57 Novolin R with no open date. During an interview on 8/6/2014 at 10:51 a.m., LPN #1 indicated the open vial of			

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	Tuberculin solution has been used and should of had an open date written on the vial. During an interview on 8/6/2014 at 3:20 p.m., RN #7 indicated the bottle of urine dip sticks are used to test the residents urine when requested by their physician. RN #7 then picked up the bottle and replaced it on the counter before leaving the medication room. During an interview on 8/6/2014 at 3:29 p.m., RN #7 indicated Resident #54 was discharged on Sunday 8/3/2014 and the insulin was not removed form the residents insulin box. RN #7 indicated Resident #66 passed away two weeks ago. RN #7 indicated the process after a resident has passed away or left the facility, is to make a list of the medication to be sent back to the pharmacy, or makes arrangement for the open medications to go with the resident's family. She indicated Resident #66's eye drops were left in the medication cart till her family comes to get them. During an observation on 8/7/2014 at 10:39 a.m., Wilson Hall medication cart, treatment cart and medication room was observed with RN #5. The medication refrigerator had one vial of injectable			

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	sterile water, with no open date. Inside the medication room freezer was a milk shake for resident #26 and ice cream for Resident #119. A policy and procedure for "Medication Storage in the Facility", with an effective sate 9/1/2013, was provided by Corporate Nurse consultant on 8/6/014 at 4:30 p.m. The policy indicated, but was not limited to, A Procedure: K. Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator. L. Outdated, contaminated, or deteriorated mediations..... disposed of according to procedures. A policy and procedure for "Date Marking," with an effective date of 2009, was provided by Corporate Nurse Consultant on 8/6/2014 at 4:30 p.m. The policy indicated, but was not limited to, A Procedure: 1. Date marking is an identification system. The system helps identify when the food was prepared and when it is to be discarded.			

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	3.1-25(j) 3.1-25(o)			
F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the			

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	disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure infection control practices were followed related to isolation precautions, hand washing and transporting linens in a manner to prevent the spread of infection for 5 of 8 observations. (Resident #53, #59, #144, #39 & general therapy use) Findings include: 1. During an observation on 8/6/2014 at 10:04 a.m. of Resident #53's wound care to the left heel, LPN #1 sat on the floor and placed all the dressing supplies on the floor beside her. After cleansing the wound LPN #1 removed her soiled gloves and replaced her gloves without washing hands. In the process of replacing the dressing on Resident #53's heel, LPN #1 used her mouth to open two packages of gauze padding. During an Interview on 8/6/14 10:32 a.m., LPN #1 indicated the policy with hand washing is to wash hands before	F000441	1. DHS immediately inserviced LPN #1 regarding infection control practices specific to dressing changes using the guideline for dressing changes. DHS/ADHS will inservice nursing staff regarding infection control practices specific to dressing change techniques per guidelines for dressing changes. DHS/ADHS will audit 2 dressing change techniques weekly x 4; 2x per month x3 months; and 1x monthly x3 to ensure infection control measures are followed. The results of the audit will be presented to the QA committee and the need for ongoing audits will be determined. 2. DHS/ADHS will inservice staff members regarding practices to prevent spread of infection while transporting towels per facility's infection control standard precautions. DHS/ADHS will audit through observation staff members transporting towels to ensure safe practices to prevent spread of infection weekly x 4; 2x per month x3 months; and 1x monthly x3. The results of the	09/04/2014

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	and after taking gloves off and in between glove changes. 2. During an observation on 8/7/2014 at 11:10 a.m., Occupational Therapy Assistant (OTA) #16 carried towels through the hallway from Tanner court yard area to Therapy room. The uncovered towels were held up against her shirt and arm to be used for the residents in Therapy. During an interview on 8/7/2014 at 11:11 a.m., OTA #16 indicated the towels are use to assist the residents with therapy for covering their heating pads During an observation 8/6/2014 at 3:57 p.m., LPN #2 carried a towel under her left arm up against her side into Resident #59's room and placed the towel on the residents stomach for protection from medication which was being administered in the Gastric tube. 3. During an observation on 8/7/2014 at 2:09 p.m., Resident #144's culture results were positive for Clostridium difficile (C-diff) Toxin dated 8/5/2014. A hand written note, on the bottom of culture indicated the stoma wound was positive for Methicillin resistant staphylococcus (MRSA).		audit will be presented to the QA committee and the need for ongoing audits will be determined. 3. DHS/ADHS will inservice on the 24 hour report sheet to ensure those resident's with C-Diff are communicated shift to shift and ensure staff members know proper precautions using the guideline for proper handwashing and the policy and procedure for Isolation. DHS/ADHS will audit through interview/observation staff members knowledge of residents on their hall who are positive for C-Diff and proper precautions weekly x2 for weekly x 4; 2x per month x3 months; and 1x monthly x3. The results of the audit will be presented to the QA committee and the need for ongoing audits will be determined. The infection control nurse will conduct ongoing surveillance rounds which will include isolation precautions, handwashing and transporting linens. The rounds will be conducted monthly and reported in the QA committee.	

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	During an interview on 8/7/2014 at 2:14 p.m., LPN #3 the policy for a resident with C-diff is contact isolation. LPN #3 indicated a note should be on the door to stop and see the nurse before entering. During an Interview on 8/7/2014 at 2:17 p.m., RN #5 indicated she spoke with the Director of Nursing (DON) and no sign is used on the door, that staff should just use gloves and place personal items in red bags. During an interview on 8/7/2014 at 2:20 p.m., Floor Technician #12 was not aware of any resident on Wilson Hall having a positive culture for C-diff. During an Interview on 8/7/2014 at 2:22 p.m., CNA #14 indicated the policy for C-diff was to use gloves and throw trash in a separate red bag. During an interview on 8/7/2014 at 2:26 p.m., RN #6 and RN #7 were not aware of any residents on their hallway currently having C-Diff. RN #7 indicated one resident was in Isolation for MRSA. During an observation on 8/7/2014 at 2:31 p.m., resident #39 moved to room 206 due to MRSA. A STOP sign is posted on the door.			

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	During an interview on 8/7/2014 at 2:41 p.m., DON indicated the policy and procedure for Isolation with a resident for C-Diff is only contact precautions. Any item with body fluid like stool would go into a red bag. The only notification is given in report for each staff member. The pre-cautions for MRSA is contact only for Gastric tubes. If their is drainage on clothing it would go into the laundry. Staff would be notified in report. If the resident is confused or disoriented and excessive drainage, diarrhea. The facility's policy dose not state a sign is necessary. If the isolation is more then just contact a cart will be placed in room. A policy and procedure for "General Guidelines for Dressing Changes", with an effective date of December 2009, was provided by Corporate Nurse Consultant on 8/6/2014 at 11:17 a.m. The policy indicated, but was not limited to , A Purpose: 2. Create a clean field with towel or towelette drape, 5. Wash hands with soap and water, 6. Put on first pair of disposable gloves, 7. Remove soiled dressing and discard in plastic bag, 8. Dispose of gloves in plastic bag, 9. Wash hands with soap and water. 10. Put on second pair of disposable gloves, 14. Remove gloves and discard with all unused supplies in plastic bag, 15. Wash hands with soap and water.....			

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	A policy and procedure for "Guidelines for Hand washing", with effective date October 2004, was provided by Corporate Nurse Consultant on 8/6/2014 at 11:17 a.m. The policy indicated, but was not limited to, A Purpose: Hand washing is the single most important factor in preventing transmission of infections. Procedure: 3. Health Care Workers shall wash hands at times such as: b. Before/after preparing/ serving meals, drinks, tube feedings, etc. d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc. A policy and procedure for "Isolation Policies", with no date noted, provided by DON on 8/7/2014 at 4:40 p.m. The policy indicated, but was not limited to, Introduction adoption by the facility of Standard Precautions..... Objectives 1. To prevent the spread of infection and communicable disease to other residents, health care workers and visitors. 2. To establish guidelines for implementation of isolation. 3. To ensure a safe, sanitary environment for residents, health care workers, visitors, and the general public. 3.1-18(b)(2)			

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	3.1-18(l) 3.1-19(g)			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain the water temperature between 100 and 120 degree Fahrenheit (F) in the residents bathroom sink in 9 of 9 resident rooms. (Rooms 111, 207, 209, 306, 702, 703, 705, 706, and 707) Findings include: On 8/4/2014, throughout the day, the following water temperatures were observed: -room # 705 the sink water was 98 degrees F. -room # 707 the sink water was 73 degrees F. -room #703 the sink water was 83 degrees F. -room #706 the sink water was 73 degrees F. -room #702 the sink water was 94	F000465	DPO immediately removed the water saver ring to ensure water temperatures reached at least 100 degrees but not higher than 120 degrees on resident rooms 705, 707, 703, 706, 702, 111, 306, 207 and 209. ED immediately inserviced DPO on need for resident water room temperatures reach at least 100 degrees but not higher than 120 degrees per regulatory requirements. DPO/ADPO will remove all water saver rings to ensure resident room water temperature reaches between 100 and 120 degrees. DPO/ADPO will audit 5 rooms per week to ensure resident room water temperature reaches between 100 and 120 degrees weekly x 4. The results of the audit will be presented to the QA committee and the need for ongoing audits will be determined.	09/04/2014

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	degrees F. - room #111 the sink water was 75 degrees F. -room #306 the sink water was 86 degrees F. -room #207 the sink water was 82 degrees F -room #209 the sink water was 84 degrees F. On 8/7/2014 at 1:45 p.m., the Director of Plant Operations (DPO) indicated each bathroom sink has a water saver ring located in the sink faucet. When that ring is in place the water flow is slower and it takes longer for the water to warm up. If a resident wants the water to warm up quicker the water saver ring is removed allowing for increase water flow and therefore the water gets warmer quicker. He indicated this water saver ring is not removed unless a resident or family member complains about the water temperature. The DPO indicated If the showers are being used the water in the pipes moves faster and allows the sink water temps to rise quicker as well. The water temperature was checked for Resident #139 after the water saver ring was removed, the water temperature in the sink reached 108 degrees F. A family member for Resident #139 indicated it was not like it is at home. The DPO indicated there are state regulations and			

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	the water can't be as hot as it is at home. 3.1-19(r)			
F009999	3.1-14 PERSONNEL (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of the cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure employees had proper dementia training within six months of employment. This effected one of ten employee files reviewed. (CNA #35)	F009999	Legacy Neighborhood Director will inservice CNA #35 according to state regulations. The AP/Payroll Specialist review all employee records for dementia training completion with no findings. The AP/Payroll Specialist will audit new employee files for completion of dementia training to verify compliance with dementia training quarterly. The audits will continue for 9 months and the results will be reported to the QA and the need for ongoing audits will be determined by the QA committee.	09/04/2014

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	Findings include: Employee files were reviewed on 8/8/2014 10: 50 a.m. The Employment records for CNA #35 indicated the hire date was on 1/14/2014. Dementia training was not noted in the file. The employee schedule indicated CNA #35 worked 14 days on 3rd shift from 7/14/2014 through 8/8/2014 on Wilson Hall. During an interview on 8/8/2014 at 10:54 a.m., the Business Office Manager indicated the Dementia training for CNA #35 was not done due to Training Staff was on Vacation. 3.1-14(u)			
R000000	These deficiencies reflect State findings in accordance with 410 IAC 16.2-5.	R000000	This plan of correction is prepared and executed because it is required by the provision of the State and Federal la and not because RidgeWood Health Campus agrees with the allegations and citations. RidgeWood Health Campus maintains that the alleged deficiencies do not jeopardize the health and safety of the residents,	

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			nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance.	
R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure an annual tuberculosis (TB) test was given to a resident for 1 of 7 residents reviewed for tuberculosis testing. (Resident #8) Finding include: Resident #8's clinical record was	R000410	Resident #8 was discharged on 7/3/2014. DHS/ADHS reviewed remaining residents to verify timely completion of annual TB screening. DHS/ADHS will inservice nursing staff regarding necessity of giving annual TB screens during the resident's anniversery month each year using facility's current policy. DHS/ADHS will audit 3	09/04/2014

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	reviewed on 8/8/2014 at 2:10 p.m. It indicated Resident #8 was readmitted to the facility on 4/25/2014. Diagnoses included, but are not limited to hypertension and hip fracture. Review of Resident #8's tuberculosis testing indicated she had first step (TB) on 4/1/2013 and read on 4/3/2013 the testing results were documented as 0 millimeters [negative]. Resident #8 received her second step (TB) on 4/20/2013 and read on 4/22/2013 the testing results were documented as 0 millimeters. No annual testing was conducted for resident #8. During an interview with LPN #40 on 8/8/2014 at 3:45 p.m., she indicated Resident #8's annual (TB) should of being giving in April 2014, I did not see it in the chart where it was given. On 8/8/2014 at 4:25 p.m., the Administrator provided a copy of the facility's current Policy and Procedure dated 3/27/2008. "Guidelines for TB Results Summary Documentation: Residents." "Procedures 7. An order should be written upon admission to re-test annually to ensure each resident is re-tested on their admission anniversary date with a one-step Mantoux or Tuberculosis Screening.... 9. Document		residents weekly x 4; 2x per month x3 months; and 1x monthly x3 to ensure proper administration of annual TB screen. The results of the audit will be presented to the QA committee and the need for ongoing audits will be determined.	

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	results of annual evaluation on the TB Results Summary in the resident's medical record...."			