

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2013
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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 22, 23, 24, 25, 28, 29, 30, and 31, 2013</p> <p>Facility number: 000559 Provider number: 155719 Aim number: 100267170</p> <p>Survey team: Regina Sanders, RN-TC Kathleen Vargas, RN (January 22, 23, 24, 25, 29, and 30, 2013) Janelyn Kulik, RN (January 22, 2013)</p> <p>Census bed type: SNF: 04 SNF/NF: 57 Total: 61</p> <p>Census payor type: Medicare: 08 Medicaid: 28 Other: 25 Total: 61</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February</p>	F0000	<p>February 15, 2013 Miriam Buffington, Enforcement Manager Division of Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-Bl Indianapolis, IN 46204-3006 Re: POC for the annual survey of George Ade Memorial Health Care Center, Brook, IN. Survey Event ID LR7C11 Health Survey Dear Miriam Buffington: This letter is in regards to the aforementioned survey that was conducted on January 31, 2013. The following plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 2 nd day of March, 2013. At this time we are requesting a desk review to clear the findings and stop any and all proposed or implemented remedies that have been presented to date. If you have any questions or need further information, call 219-275-2531 or fax 219-275-7472, and we will be available to assist you in any way possible. Thank you, W R Scott James, HFAGAMHCC c: survey file February 20, 2013 Janelyn Kulik, RNSurveyor Supervisor Long Term Care Division Indiana State Department of Health The following information is in response to the request dated February 19, 2013,</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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	5, 2013, by Janelyn Kulik, RN.		<p>for facility #000559, Provider #155719, Survey Event ID: LR7C11, with Survey Date: January 31, 2013. The amended responses are all marked with an *</p> <p>February 25, 2013</p> <p>Janelyn Kulik, RN Surveyor Supervisor Long Term Care Division Indiana State Department of Health</p> <p>Facility #: 000559 Provider #: 155719 Survey Event ID: LR7C11 Survey Date: January 31, 2013</p> <p>Addendum:</p> <p>Tags F225, F226, F241, F282 and F332.</p> <p>Audits will be presented for QA committee review at the bi-monthly meetings. Upon achieving a 95 % to 100 % compliance rate, committee may remove from review. If compliance rate is not met, the review will continue with monthly audit to achieve compliance rate. Results will be presented to QA meeting for review.</p> <p>The amended responses are all marked with an **</p> <p>The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the</p>		

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			<p>conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensure of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective action was necessary.</p>		

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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to provide ongoing information to the residents related to the process to formally file a complaint with the State Agency. This deficient practice had the potential to affect 61 of 61 residents residing in the facility. (Resident #47)</p> <p>Findings include:</p> <p>Interview with Resident #47 on 1/29/13 at 2:15 p.m., indicated she attended Resident Council meetings regularly. She indicated she was not aware of how to formally file a complaint with the State about the care the residents were receiving at the facility. She did not recall being informed by facility staff during Resident Council meetings or at any other time of how to formally voice a</p>	F0156	<p>The information regarding the process/contact to formally voice a complaint to the state, has been made available to the residents. This information will be covered during admission and at the regularly scheduled residents' council meetings. This will assist in keeping the residents informed of the required information to include how to voice a complaint to the state.</p> <p>This will be covered during regularly scheduled resident council meetings to assure compliance. This will be the responsibility of the Activities Coordinator and/or designee and Administrator to see this is done.</p> <p>On 2/14/13, our staff was in-serviced to assure compliance.</p> <p>See attached form.</p>	03/02/2013	

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	<p>complaint to the State.</p> <p>The record for Resident #47 was reviewed on 1/29/13 at 3:06 p.m. The quarterly Minimum Data Set (MDS) assessment, dated 11/15/12, was reviewed. It indicated the resident's Brief Interview for Mental Status (BIMS) was 15, which indicated she was cognitively aware.</p> <p>Interview with The Activity Director on 1/29/13 at 2:30 p.m., indicated she attended the Resident Council meetings. She indicated there had been no information provided to the residents during the council meetings related to how to formally file a complaint with the State.</p> <p>Review of the 2012 Resident Council meeting minutes on 1/29/13 at 2:25 p.m., indicated there was no evidence the residents were informed of how to formally file a complaint with the State Agency.</p> <p>3.1-4(a)</p>		This is done as of 3/2/13.		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F0225	In review of the cited allegations it	03/02/2013			

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	<p>interview, the facility failed to report an allegation of abuse to the Indiana State Department of Health (ISDH) and failed to report an allegation of abuse timely to the Administrator of the facility for 2 of 3 abuse allegations reviewed. (Residents #5 and #75) (CNA #2 and CNA #3)</p> <p>Findings include:</p> <p>1. A "Fax/Incident Report", reviewed on 01/30/13 at 9 a.m., indicated an incident was reported to the Administrator on 10/05/12 at 2:30 p.m. The report indicated CNA #2 had reported to the Administration that CNA #3 had commented during report on 10/03/12 how she (CNA #3) would treat a resident (Resident #75) when providing care. The report indicated CNA #2 had felt the comments were possibly abusive. CNA #2 did not report the concern until 10/05/12 (2 days later).</p> <p>A signed statement by CNA #2, dated 10/05/12 at 2:30, indicated, "on Wed (Wednesday) (10/03/12) night shift report (CNA #2) gave report again to (CNA #3). She (CNA #3) said with (Resident #75) she told him the previous night that she said to (Resident #75) 'She is boss and he will turn for her'. The next night (CNA</p>		<p>was determined that no actual harm was found for resident #5 and #75. The facility investigates all alleged violation thoroughly. As of 2/14/13, the staff has been in-serviced on resident rights and reporting of abuse. Employee name badges revised to include "immediately" as a part of the abuse reporting. (Review of P&P revised). QA will review for changes. The attached audit sheet will be used to sample staff weekly times 3 months for compliance. Results will be reviewed at QA meeting. QA committee will determine need for further review. This is done as of 3/2/2013.* Copy of revised policy and procedure is included, tagged as F225.**Audits will be presented for QA committee review at the bi-monthly meetings. Upon achieving a 95 % to 100 % compliance rate, committee may remove from review. If compliance rate is not met, the review will continue with monthly audit to achieve compliance rate. Results will be presented to QA meeting for review.</p>				

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	<p>#2) gave report to (CNA #3) again (10/04/12), that she (CNA #3) again (sic) told him again 'she is boss and he will do what she says' I guess when she pushed him over and he (Resident #75) tried to punch her she ducked after this...roommate...said he would have taken care of him if that happened. She told (roommate) if that happened there would be nothing left of him..."</p> <p>A letter written to the ISDH from the Administrator, dated 10/08/12, indicated the facility had completed an investigation and had concluded no abuse had taken place.</p> <p>During an interview on 01/30/13 at 9 a.m., the Administrator indicated he did not know why the CNA did not report the concern immediately. He indicated the CNA's are to report concerns immediately to the nurse on duty who will then notify him immediately.</p> <p>2. Resident #5's record was reviewed on 01/28/13 at 2 p.m. The resident's diagnoses included, but were not limited to, behavioral problems and anxiety.</p> <p>A nursing progress note, dated 01/09/13 at 2:54 p.m., indicated,</p>				

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	<p>"Reported by daughter socially inappropriate behaviors with (sic) social services notified...."</p> <p>An investigation form, dated 01/10/13, indicated, "Description of Incident/Allegation: Resident hit his roommate (sic) with a blue towel as witnessed by his daughter...Did the incident/allegation meet the definition of abuse...yes (circled)...Immediate corrective actions taken for the involved resident include...:" (1) Remove resident from room (2)Room changes at present...contacted resident's doctor in regards to possibility of sending resident to outside facility to address increased aggression..."</p> <p>There was a lack of documentation to indicate the allegation had been reported to the ISDH.</p> <p>During an interview on 01/28/13 at 3:26 p.m., the Administrator indicated the staff reported to him and the Social Service Director immediately and they looked into it immediately. He indicated there was no actual harm or intent. He indicated the facility had missed a step and had not reported the allegation.</p> <p>3.1-28(c)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the facility's policy for reporting allegations of abuse to the Administrator and reporting to the Indiana State Department of Health (ISDH) allegations for 2 of 3 allegations reviewed for abuse allegations. (Residents #5 and #75)</p> <p>Findings include:</p> <p>1. A "Fax/Incident Report", reviewed on 01/30/13 at 9 a.m., indicated an incident was reported to the Administrator on 10/05/12 at 2:30 p.m. The report indicated CNA #2 had reported to the Administration that CNA #3 had commented during report on 10/03/12 how she (CNA #3) would treat a resident (Resident #75) when providing care. The report indicated CNA #2 had felt the comments were possibly abusive. CNA #2 did not report the concern until 10/05/12 (2 days later).</p>	F0226	<p>In review of the cited allegation it was determined that no actual harm was found to have taken place for resident #5 and #75. It is the practice of the facility to investigate all allegations thoroughly. Staff members have been in-serviced on the proper reporting sequence. This will be reviewed on an annual basis and as the need may arise. All staff included in this review. Administrator, DON, SS and/or designees are responsible to see this is audited and/or reviewed. Results will be presented to QA for review. Necessity to continue audits will be determined through QA review. Policy has been reviewed /revised and presented to all staff. This is done as of 2/14/2013.*Will be monitored weekly; Administrator, DON, Social Services and/or designee will be responsible for monitoring. Monitoring will be done three times a week for two weeks, then one time a week for two weeks. Refinements and modification will be implemented as deemed necessary. Audits and review information will be presented at the bi-monthly QA</p>	02/14/2013	

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	<p>A signed statement by CNA #2, dated 10/05/12 at 2:30, indicated, "on Wed (Wednesday) (10/03/12) night shift report (CNA #2) gave report again to (CNA #3). She (CNA #3) said with (Resident #75) she told him the previous night that she said to (Resident #75) 'She is boss and he will turn for her'. The next night (CNA #2) gave report to (CNA #3) again (10/04/12), that she (CNA #3) again (sic) told him again 'she is boss and he will do what she says' I guess when she pushed him over and he (Resident #75) tried to punch her she ducked after this...roommate...said he would have taken care of him if that happened. She told (roommate) if that happened there would be nothing left of him..."</p> <p>A letter written to the ISDH from the Administrator, dated 10/08/12, indicated the facility had completed an investigation and had concluded no abuse had taken place.</p> <p>During an interview on 01/30/13 at 9 a.m., the Administrator indicated he did not know why the CNA did not report the concern immediately. He indicated the CNA's are to report concerns immediately to the nurse on duty who will then notify him</p>		committee meetings**Audits will be presented for QA committee review at the bi-monthly meetings. Upon achieving a 95 % to 100 % compliance rate, committee may remove from review. If compliance rate is not met, the review will continue with monthly audit to achieve compliance rate. Results will be presented to QA meeting for review.				

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	<p>immediately.</p> <p>2. Resident #5's record was reviewed on 01/28/13 at 2 p.m. The resident's diagnoses included, but were not limited to, behavioral problems and anxiety.</p> <p>A nursing progress note, dated 01/09/13 at 2:54 p.m., indicated, "Reported by daughter socially inappropriate behaviors with (sic) social services notified...."</p> <p>An investigation form, dated 01/10/13, indicated, "Description of Incident/Allegation: Resident hit his roommate (sic) with a blue towel as witnessed by his daughter...Did the incident/allegation meet the definition of abuse...yes (circled)...Immediate corrective actions taken for the involved resident include...:" (1) Remove resident from room (2)Room changes at present...contacted resident's doctor in regards to possibility of sending resident to outside facility to address increased aggression..."</p> <p>There was a lack of documentation to indicate the allegation had been reported to the ISDH.</p> <p>During an interview on 01/28/13 at</p>				

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	<p>3:26 p.m., the Administrator indicated the staff reported to him and the Social Service Director immediately and they looked into it immediately. He indicated there was no actual harm or intent. He indicated the facility had missed a step and had not reported the allegation.</p> <p>An undated facility policy, received from the Administrator on 01/23/13 at 10 a.m., titled, "Resident Abuse", indicated, "...The report of alleged mistreatment, neglect or abuse must be reported to the Administrator or his/her designee immediately. C. The Administrator or his/her designee will notify the following persons immediately, by phone and in writing, of the alleged mistreatment, neglect, or abuse: 1. State Licensing and Certification Agency..."</p> <p>3.1-28(a)</p>						

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, that facility failed to ensure the resident's dignity was maintained, related to the lack of utilizing a dignity bag for a resident with a urinary catheter in place for 1 of 3 residents reviewed for urinary catheter use of the 13 residents who met the criteria for urinary catheter use. (Resident #21)</p> <p>Findings include:</p> <p>Resident #21 was observed on 1/23/13 at 10:36 a.m. The resident was seated in her room in a recliner chair. The resident was observed to have a urinary catheter in place (a tube inserted into the bladder to drain urine). The urinary catheter drainage bag was attached to the bottom of the chair and had a collection of yellow urine in it. The drainage bag was not in a dignity bag, a bag that is opaque and does not allow the urine to be observed.</p> <p>On 1/25/13 at 1:27 p.m., the resident</p>	F0241	<p>Dignity Dignity bag on resident #21 was immediately placed and utilized. Policy on catheter covers/dignity bag was reviewed. Every resident with a catheter was audited to ensure dignity covers were utilized. All nursing staff in-serviced on catheter cover/dignity bag covers policy and procedure. Catheter bags with catheter covers included in product were ordered per central supply and will be placed on every resident with a catheter bag as their due date occurs for catheter bag maintenance approached. Upon Hire nursing staff will be educated on catheter care procedures and use of dignity bags. QA: Catheters will be audited weekly x 5 for 4 weeks then upon review of QA team's discretion to evaluate how often catheter audits to occur. This is done as of 3/2/13.* DON and/or designee or charge nurse will be responsible to monitor. This will be done, three times a week for two weeks, then one time a week for two weeks. Refinement and modification will be implemented as deemed necessary. This will be reviewed at the bimonthly QA meetings. (Refer to F241 and</p>	03/02/2013	

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	<p>was observed in bed. The urinary catheter drainage bag was attached to the side of the bed, it was not in a dignity bag. Continued observation at that time, indicated there was a dignity bag attached to the bed frame on the opposite side of the bed. The dignity bag was not being utilized.</p> <p>Interview with CNA#1 on 1/25/13 at 1:27 p.m., indicated the resident's urinary drainage bag was not stored in a dignity bag. She indicated it should be placed inside the dignity bag.</p> <p>The record for Resident #21 was reviewed on 1/28/13 at 8:41 a.m. The resident had diagnoses that included, but were not limited to, neurogenic bladder and diabetes.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 11/22/12, indicated the resident had an indwelling catheter in place.</p> <p>There was a care plan, dated 2/24/12, that indicated the resident required an indwelling urinary catheter related to the diagnosis of neurogenic bladder and history of urinary tract infections. One of the interventions for the care of the urinary catheter indicated, "store collection bag inside</p>		F282 audit form.)**Audits will be presented for QA committee review at the bi-monthly meetings. Upon achieving a 95 % to 100 % compliance rate, committee may remove from review. If compliance rate is not met, the review will continue with monthly audit to achieve compliance rate. Results will be presented to QA meeting for review.				

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	<p>a protective dignity pouch. Do not allow tubing or any part of the drainage system to touch the floor."</p> <p>Interview with the Director of Nursing on 1/28/13 at 10:30 a.m., indicated the resident's urinary drainage bag should have been placed in the dignity bag.</p> <p>3.1-3(t)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop care plans related to, antianxiety medications, insomnia medications and pain medications for 2 of 24 records reviewed for care plans. (Resident #60 & Resident #68)</p> <p>Findings include:</p> <p>1. The record for Resident #68 was reviewed on 1/24/13 at 9:36 a.m. The resident had diagnoses that included, but were not limited to, anxiety, insomnia and depression.</p>	F0279	<p>Care plans for residents #60 and #68 have been developed to address the specific medications as cited. All charts will be reviewed for medication involving anti psychotics, insomnia and pain medication and care plans developed if not present.</p> <p>Any resident reviewed/orders for anti-anxiety medications will be care planned to address the specific needs of the resident. Any resident receive a new order for anti-anxiety, insomnia and pain medication will have a care plan developed. Orders for these are reviewed daily, 5 days weekly</p>	03/02/2013	

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	<p>The resident's current Physician's Orders were reviewed. There was a Physician Order dated 9/26/12, that indicated, "Ativan (an antianxiety medication) 1 mg (milligram) q (every) 2 hours prn (as needed) for anxiety."</p> <p>There was a Physician Order dated 11/22/12, that indicated, "Ambien (a medication for sleep) 11 mg at hs (hour of sleep) prn for sleep."</p> <p>There was a Physician Order dated 9/26/12, that indicated, "Xanax (an antianxiety medication) 0.25 mg tid (three times a day) prn for anxiety."</p> <p>The resident's current care plans were reviewed. There were no care plans for the use of Ambien or for insomnia. There were no care plans for anxiety or the use of Xanax or Ativan.</p> <p>Interview with the MDS Coordinator on 1/25/13 at 9:04 a.m., indicated there were no care plans for the use of Ambien or for the use of Xanax and Ativan. She indicated there should have been care plans initiated for the use of the medication for insomnia and the use of the antianxiety medications.</p> <p>2. Resident # 60's record was</p>		<p>for compliance during regular morning meetings.</p> <p>Reports for facility PRN medication notes will include the anti-anxiety, pain medication and insomnia are checked weekly to insure care plans are in place, audit results will be review in QA for frequency. The DON and/or designee is responsible to follow up.</p> <p>This is done as of 3/2/13.</p>	

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	<p>reviewed on 01/26/13 at 2 p.m. The resident's diagnoses included, but were not limited to pain and dementia.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, dated 11/08/12, indicated the resident had occasional pain in the last 5 days and the pain intensity was a 4 on a scale of 1-10.</p> <p>A monthly assessment, dated 11/8/12, indicated the resident had pain daily and at times the pain was horrible or excruciating.</p> <p>A "Pain Interview", dated 11/12/12, indicated the resident received a Duragesic (narcotic pain medicine routinely) patch, received as needed pain medication in the last five days, pain was present, occasional pain in the last five days, was rated 4 on a scale of 1-10 and to continue the current plan of care.</p> <p>The Physician's Orders indicated an order, dated 04/04/12, for Duragesic Patch 12 micrograms per hour, every 72 hours, an order, dated 02/23/12 for acetaminophen 325 mg, two tablets every six hours as needed for pain, and an order, dated 02/23/12, for Norco (pain medicine) 5-325 milligrams every six hours as needed</p>				

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	<p>for pain.</p> <p>The Medication Administration Record, dated 12/12, indicated the resident received the as needed Norco on December 1, 4, 9, 17, 20, 24 (twice), and 26, 2012.</p> <p>The care plans, dated 11/15/12, lacked documentation to indicate the resident's pain had been care planned.</p> <p>During an interview on 01/28/13 at 10:16 a.m., the MDS Nurse indicated there was no care plan for the resident's pain. She indicated there should have been a care plan implemented.</p> <p>3.1-35(a)</p>				

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be 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.</p> <p>Based on observation, record review and interview, the facility failed to review and revise the resident's care plan, related to behaviors for 1 of 24 residents reviewed for care plans. (Resident #63)</p> <p>Findings include:</p> <p>Resident #63 was observed on 1/24/13 at 8:18 a.m. He was in the Main Dining eating breakfast with metal utensils.</p> <p>The resident was observed on 1/25/13 at 8:30 a.m., in the main dining room feeding himself breakfast</p>	F0280	<p>The care plan for resident #63 has been reviewed and revised, related to behaviors. All other resident with behavior management plan may have the potential to be effected. Residents currently on the behavior program with care plan have been reviewed and revised as appropriate.</p> <p>Review of behavior management policy with nursing staff, and provided training for such to insure behavior management plan are understood.</p> <p>Any resident returning from a psychiatric hospital stay will have their care plan reviewed and</p>	03/02/2013			

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	<p>with metal utensils.</p> <p>Resident #63's room was observed on 1/29/13 at 10:02 a.m. There were electric cords for the television and the electric razor. There were cords for the bed alarm and for the call lights. There was no surveillance camera in the room.</p> <p>The record for Resident #63 was reviewed on 1/29/13 at 8:55 a.m. The resident had diagnoses that included, but were not limited to, dementia with behavioral disturbance, depression and anxiety.</p> <p>There was a Progress Note written by the Social Service Director dated 10/17/12, that indicated, "Completed MDS (Minimum Data Set) Assessment for ARD (Assessment Reference Date) of 10/17/12. Resident participated in assessment. Completed BIMS (Brief Interview for Mental Status) on 10/17/12 with a score of 10, indicating the the resident's cognition is moderately impaired. Resident has had an acute change in BIMS which was previously 14 (indicating cognitively intact). Completed mood interview on 10/17/12 with a score of 14, indicating signs and symptoms of moderate depression. Resident triggered for</p>		<p>revised upon readmission to assure that the alleged deficient practice doesn't reoccur.</p> <p>Any resident returning from a psychiatric hospital stay will be reviewed with care plan revised within 72 hours of return.</p> <p>Social Service Coordinator and or designee will be responsible.</p> <p>Results will be reviewed by QA committee to determine if further monitoring is needed.</p> <p>This is done as of 3/2/13.</p>		

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	<p>feeling depressed (7-11 days), trouble sleeping (7-11 days), feeling tired (12-14 days), feeling bad about self (7-11 days), trouble concentrating (12-14 days) , thoughts of better off dead and hurting self (7-11 days). Writer will notify counselor and Doctor . . . "</p> <p>The Physician and Counselor were notified of the resident's statements. The Progress Note dated 10/17/12 at 1:42 p.m., indicated the resident's belts and cords were removed from the resident's room. The resident was placed on Suicide Prevention Observation on 10/17/12.</p> <p>On 10/22/12 at 10:33 a.m., the facility obtained a Physician Order to discharge the resident to a Psychiatric Hospital for evaluation and treatment. The resident was transferred to the Psychiatric Hospital on 10/22/12 at 4:11 p.m.</p> <p>The resident returned to the facility on 10/26/12. Review of the discharge orders from the Psychiatric Hospital indicated there were no orders for Suicide Precautions.</p> <p>The current care plans were reviewed. There was a care plan dated 10/26/12 that indicated,</p>				

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	<p>"Resident #63's name) returned from (Psychiatric Hospital's name) with suggestions to observe closely for safety Goal: (Resident #63's name) will be kept safe thru (through) this assessment period -24 hour surveillance monitoring via camera has been installed -allow/encourage conversation with (Resident #63's name), notify charge nurse if (Resident #63's name) verbalized any statements or is observed in any actions which could be interpreted as potential for harm -encourage (Resident #63's name) to remain in high traffic areas while up -ensure any objects which can be used for self harming are not readily available to (Resident #63's name) - (Resident #63's name) will remain in observation room next to nurses station"</p> <p>Interview with the Director of Nursing on 1/29/13 at 10:50 a.m., indicated the resident's care plan did not reflect the resident's current status. She indicated the resident's Psychosocial Well-Being assessment completed on 11/9/12, indicated the resident had no thoughts of being better off dead or of hurting himself. She indicated the resident no longer required a 24 hour surveillance camera. She also</p>						

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	<p>indicated the resident did not need to be kept away from cords and objects that he could harm himself with. She indicated the resident's current care plan had not been reviewed and revised to reflect the resident's current status.</p> <p>3.1-35(d)(2)(B)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, that facility failed to ensure the resident's care plan was followed, related to a dignity bag not in use for 1 of 24 residents reviewed for care plans. (Resident #21)</p> <p>Findings include:</p> <p>Resident #21 was observed on 1/23/13 at 10:36 a.m. The resident was seated in her room in a recliner chair. The resident was observed to have a urinary catheter in place (a tube inserted into the bladder to drain urine). The urinary catheter drainage bag was attached to the bottom of the chair and had a collection of yellow urine in it. The drainage bag was not in a dignity bag, a bag that is opaque and does not allow the urine to be observed.</p> <p>On 1/25/13 at 1:27 p.m., the resident was observed in bed. The urinary catheter drainage bag was attached to the side of the bed, it was not in a dignity bag. Continued observation at that time, indicated there was a</p>	F0282	<p>Catheter bag immediately placed and immediately utilized to provide dignity. All residents with catheter bags audited immediately and care plans reviewed to ensure use of catheter/dignity bags placed. All residents have potential to be affected. Auditing of dignity bags being utilized to protect resident's dignity to be done weekly x 5 for 4 weeks then to be reviewed by QA team and continued at the discretion of the QA team upon review Nursing staff was in-serviced on dignity bag use. This is done as of 3/2/2013. *DON and/or designee or charge nurse will be responsible to monitor. This will be done, three times a week for two weeks, then one time a week for two weeks. Refinement and modification will be implemented as deemed necessary. This will be reviewed at the bimonthly QA meetings. (Refer to F241 and F282 audit form.)**Audits will be presented for QA committee review at the bi-monthly meetings. Upon achieving a 95 % to 100 % compliance rate, committee may remove from review. If compliance rate is not met, the review will continue with</p>	03/02/2013			

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	<p>dignity bag attached to the bed frame on the opposite side of the bed. The dignity bag was not being utilized.</p> <p>Interview with CNA#1 on 1/25/13 at 1:27 p.m., indicated the resident's urinary drainage bag was not stored in a dignity bag. She indicated it should be placed inside the dignity bag.</p> <p>The record for Resident #21 was reviewed on 1/28/13 at 8:41 a.m. The resident had diagnoses that included, but were not limited to, neurogenic bladder and diabetes.</p> <p>There was a care plan, dated 2/24/12, that indicated: "(Resident #21's name) requires an indwelling urinary catheter r/t (related to) dx (diagnosis) of neurogenic bladder and history of uti's (urinary tract infections) Goal: (Resident #21's name) will have catheter care managed and no s/s (signs and symptoms) of uti -assess drainage -change cath (catheter) monthly and prn (as needed) with 18 Fr (French) 10 cc (cubic centimeter) bulb -encourage fluids -keep system closed as much as possible -(Resident #21's name) has dx of</p>		monthly audit to achieve compliance rate. Results will be presented to QA meeting for review.		

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	<p>bladder spasms and is on Detrol (a medication for bladder spasms) 4 mg (milligrams) day, -manipulate tubing as little as possible during care -may irrigate prn -measure and record output -provide cath care bid (twice daily) cleansing with warm water and soap, washing down tubing away from insertion site -monitor for s/s of uti and report to MD (physician) -store collection bag inside a protective dignity pouch. Do not allow tubing or any part of the drainage system to touch the floor."</p> <p>Interview with the Director of Nursing on 1/28/13 at 10:30 a.m., indicated the resident's care plan was not followed. She indicated the resident's urinary drainage bag should have been placed in a dignity bag.</p> <p>3.1-35(g)(2)</p>				

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview the facility failed to ensure residents were free of hazards related to, bed side rail measurements over 4 3/4 inches in diameter for 11 of 61 beds occupied in the facility. (Residents #5, #14, #15, #30, #35, #45, #53, #55, #60, #63, and #67)</p> <p>Findings include:</p> <p>During an observation on 01/22/13 at 10:55 a.m., Resident # 14's, #53's, #5's, #60's, #35's, #30's, and #15's bed side rail measurements of the center opening was 7 1/2 x 17 3/4 inches and the side opening of the rails were 5 1/2 x 16 1/2 inches.</p> <p>Resident #55's bed side rail measurements of the center openings were 8 1/2 x 10 1/2 inches and the side opening of the rails were 7 x 10 inches.</p> <p>Resident # 45's, #63, and #67's bed side rail measurements of the center openings were 7 1/2 x 17 1/4 inches</p>	F0323	<p>Bed rails for resident beds #5, #14, #15, #30, #35, #45, #53, #55, #60, #63 and #67 have been replaced to ensure residents are free of hazards. All beds throughout the facility have been checked with correct bed rails replaced if need. All non compliant rails have been discarded to prevent further concerns. Only bedrails of correct proportion will be used on resident care beds. This is checked monthly for proper usage. This is the responsibility of the restorative nursing department for compliance with review at bi-monthly QA meetings. This is done as of 3/2/13.</p>	03/02/2013			

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	<p>and the side opening of the rails were 7 x 10.</p> <p>During an interview on 01/22/13 at 11:25 a.m. the Administrator indicated there had been no reported problems with bed side rails. He indicated there were other bed side rails they could switch them with.</p> <p>3.2-45(a)(1)</p>			

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview the facility failed to ensure a medication error rate of less than 5%, related to medications not given at the correct time and a medication omitted. There were 5 medication errors observed during 52 opportunities for error, resulting in a medication error rate of 9.61%, for 3 of 14 residents observed during Medication Administration Pass. (Residents #32, #50, and #68)</p> <p>Findings include:</p> <p>1. LPN #1 was observed on 1/24/13, during the Medication Administration Pass. She prepared the medications for Resident #50. One of the medications prepared for the resident was levothyroxine (a medication for the treatment of hypothyroidism). On 1/24/13 at 7:50 a.m., she gave the resident her medications which included the levothyroxine. The resident was in the Main Dining Room, drinking her coffee and waiting for her breakfast tray to be served. Her breakfast tray was served within 5 minutes of receiving</p>	F0332	<p>Levothyroxine and Omeprazole will be given at 5 am +/- 1 hour. Of course a physician can supersede a given time frame by specifying an administration time per facility policy. Physician of resident #32 and #60 were notified of the time oral medications given. Time corrected to give drug at same time each day on an empty stomach preferably ½ to 1 hour before breakfast according to facility policy. MD notified of medication omission for resident #50. No adverse reaction noted. LPN #1 was counseled. All residents are to be reviewed for any taking omeprazole or levothyroxine. Orders reviewed and given according to facility Policy unless superseded by a written physician's order. Policy reviewed with QA team. All residents have the potential to be affected by missed dose of medications Medication Pass audit and medication pass competency performed on every nurse. Random auditing will be done 2-3 times per week for 4 weeks then review and at discretion of the QA team. This is done as of 3/2/2013. *Licensed staff involved was counseled and corrective action taken, regarding</p>	03/02/2013

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	<p>her medications, at 7:55 a.m.</p> <p>The record for Resident #50 was reviewed on 1/24/13 at 10:20 a.m. The resident's diagnosis included, but was not limited to, hypothyroidism. There was a current Physician Order dated 11/27/12, that indicated, "levothyroxine 137 mcg (micrograms) 1 tablet daily for hypothyroidism once a day, 7 a.m.-10 a.m."</p> <p>Interview with LPN #1 on 1/24/13 at 11:05 a.m., indicated there was a drug book on the unit that was utilized by the staff as a reference. The drug book titled "Nursing 2013 Drug Handbook" was at the Elm Court Nurses' Station. The book was reviewed. It indicated levothyroxine was to be administered: "oral-Give drug at same time each day on an empty stomach, preferably 1/2 to 1 hour before breakfast."</p> <p>Interview with LPN #1 at 11:05 a.m., indicated she did not give Resident #50's levothyroxine 1/2 to 1 hour before her breakfast.</p> <p>2. On 1/24/13 at 7:55 a.m., LPN #1 was observed preparing medications for Resident #68, she set up up 8 oral pills in a medication cup for the resident. Interview with LPN #1 at that</p>		<p>resident #68. No adverse effects were noted, as related to this medication administration for resident #68. Medication pass observation audit will be conducted for each licensed staff to assure proper medication administration. DON and/or designee will be responsible for the audits. This will be done three times per week for two weeks, and then two times per week for two weeks, and then one time per week for two weeks of a random sample to verify compliance, thereafter on an annual basis unless otherwise indicated. Results will be presented to bimonthly QA committee for review and or recommendation.**Audits will be presented for QA committee review at the bi-monthly meetings. Upon achieving a 95 % to 100 % compliance rate, committee may remove from review. If compliance rate is not met, the review will continue with monthly audit to achieve compliance rate. Results will be presented to QA meeting for review.</p>				

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	<p>time, indicated there were 8 pills in the medication cup. She gave the 8 pills to the resident. Two of the 8 medications were omeprazole (a medication for gastric reflux disease) and synthroid (levothyroxine a medication for hypothyroidism). The medication buspirone (an antianxiety medication) was not prepared and was not administered to the resident. The resident had her breakfast tray served and was eating breakfast when LPN #1 administered the medications.</p> <p>The record for Resident #68 was reviewed on 1/24/13 at 9:36 a.m. The resident had diagnoses that included, but were not limited to, diabetes, hypothyroidism and gastric reflux disease.</p> <p>There was a current Physician Order dated 9/26/12, that indicated, "omeprazole 20 mg (milligrams) once a day 7 a.m.-10 a.m."</p> <p>There was a current Physician Order dated 9/27/12, that indicated, "synthroid (levothyroxine) 50 mcg (micrograms) one tablet daily for hypothyroidism 7 a.m.-10 a.m."</p> <p>There was a current Physician Order dated 11/22/12, that indicated,</p>						

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	<p>"buspirone 15 mg 1 tablet for depressive disorder once a day 7 a.m.-10 a.m."</p> <p>Review of the electronic medication administration record on 1/24/13 at 11:01 a.m., indicated the buspirone was charted as administered to the resident on 1/24/12 at 7 a.m. -10 a.m..</p> <p>Interview with LPN #1 on 1/24/13 at 11:01 a.m., indicated she had given 8 pills to the resident and the buspirone was not given as ordered. She reviewed the ordered medications for the 7 a.m. to 10 a.m. pass and indicated there should have been 9 medications administered to the resident. She indicated she did not know how she could have omitted the buspirone.</p> <p>Interview with LPN #1 at 11:05 a.m., indicated she did not give Resident #68's levothyroxine 1/2 to 1 hour before her breakfast and she did not give the omeprazole 1 hour before her breakfast. She indicated the resident was eating breakfast when the medications were administered.</p> <p>On 1/28/13 at 9:38 a.m., the Director of Nursing was interviewed. She</p>			

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	<p>indicated the levothyroxine and the omeprazole should be given prior to meals as per the facility policy. She also indicated the medication buspirone should have been administered as per order.</p> <p>3. During an observation on 01/24/13 at 8:26 a.m., Resident #32 had returned to her room after eating her breakfast, and RN #4 prepared the resident's morning medications, which included levothyroxine (thyroid medication) 100 micrograms. RN #4 then administered the resident's medications to the resident.</p> <p>The resident's record was reviewed on 01/24/13 at 10 a.m. The resident's diagnosis included but was not limited to, hypothyroidism.</p> <p>The Physician's Orders, indicated an order, dated 12/04/12, for levothyroxine 100 micrograms daily.</p> <p>During an interview on 01/25/13 at 11:24 a.m., the Minimum Data Set Nurse indicated the resident's physician was notified and he wanted the levothyroxine given before breakfast.</p> <p>Interview with LPN #1 on 1/24/13 at 11:05 a.m., indicated there was a drug book on the unit that was utilized</p>						

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	<p>by the staff as a reference. The drug book titled "Nursing 2013 Drug Handbook" was at the Elm Court Nurses' Station. The book was reviewed. It indicated levothyroxine was to be administered: "oral-Give drug at same time each day on an empty stomach, preferably 1/2 to 1 hour before breakfast." The drug book indicated administration for the medication omeprazole, "-Give drug at least 1 hour before meals."</p> <p>The policy titled, "George Ade Memorial Health Care Center," was provided on 1/25/12, by the Director of Nursing. The policy was dated 9/11/12, and the Director of Nursing indicated it was current.</p> <p>The policy indicated: "Effective September 11th, 2012, the medication administration policy will change to accommodate a more resident centered care approach. Medication administration guidelines: q AM Every Morning 7-10 AM q D Every day 7-10 AM b.i.d. Twice a Day 7-10 AM and 4-7 PM t.i.d. Three times per Day 8 AM, Noon, and 4 PM q.i.d. Four times a Day 8 AM, Noon, 4</p>						

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	<p>PM, 8 PM H.S. Bedtime 7-10 PM Medication times not reflecting a time window will be given at +/- hour Fosomax, Synthroid (levothyroxine), and Prilosec (omeprazole) will be given at 5 am +/- hour Lasix b.i.d. will be given 8-10 AM and 2-4 PM Other administration times will remain as they are. Of course a physician can supercede a given time frame by specifying administration time. Administration times for medications that must be given with food will be adjusted to be given before or after a meal depending on ac (before meal) or pc (after meal)."</p> <p>3.1-48(c)(1)</p>			

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on record review, observation and interview, the facility failed to post the daily nursing staff hours in a place which was accessible to the residents and the visitors of the facility for 4 out of 6 days. This had the potential to</p>	F0356	The posted nurse staffing information was available and was posted in a prominent area on 1/25/13. The required postings are available and maintained in a prominent location for access to residents and public. The	02/01/2013			

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	<p>affect 61 residents who reside in the facility.</p> <p>Findings include:</p> <p>During observations on 01/22/13 at 9:30 a.m., 01/23/13 at 8 a.m., 01/24/13 at 8 a.m., and 01/25/13 at 8 a.m., there was a lack of documentation posted to indicate the nursing staff hours in the facility.</p> <p>During an interview on 01/25/13 at 8:30 a.m., the DoN (Director of Nursing) indicated the hours are on kept on a clip board at desk.</p> <p>During an observation with the DoN present, at the time of the interview, the nursing staff hours were written on a form, and were placed on a clip board, which was turned over, at the Nurses' Station desk. The DoN indicated the hours were not accessible to the public.</p> <p>During an interview on 01/25/13 at 8:35 a.m., the Restorative Nurse indicated the nursing staff hours should have been hung up. She indicated she would get something to post the hours so they would be accessible to the residents and the public.</p>		<p>restorative nurse coordinator and or designee will be responsible to see that this is done and maintained on a daily basis to maintain compliance. Nursing staff (licensed personnel) were in-serviced on 2/14/13. This is done as of 2/1/2013 Sign in sheet.</p>		

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	3.1-13(g)				

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was prepared under sanitary conditions related to the improper sanitizing solution concentration for the 3 compartment sink and for 1 of 1 sanitizing bucket in 1 of 1 kitchen, and dirty ice machines in 2 of 2 nutritional pantries. This deficient practice had the potential to affect 61 of 61 residents who consumed foods prepared in the facility kitchen. (Main Kitchen)</p> <p>Findings include:</p> <p>1. On 1/22/13 at 9:01 a.m., the Brief Kitchen Sanitation Tour was completed with the Dietary Coordinator. There was a sanitizing bucket on the food prep table. The Dietary Coordinator tested the sanitizing solution in the bucket. The solution registered 100 PPM (parts per million).</p> <p>Interview with the Dietary Coordinator</p>	F0371	<p>The sanitizing buckets were refilled and tested at the correct PPM as required. The ice machines noted have been cleaned and are maintained in an acceptable and sanitary condition. The sanitization buckets and 3 compartment sinks are maintained at a proper PPM as required so as to prevent further issues. The ice machines are maintained in proper working condition at all times. Policy for the 3 compartment sink, and sanitizing buckets have been reviewed/revised. The revisions were presented to dietary staff on February 6, 2013. A revised sanitizer log was also reintroduced for staff use. Daily X 5 for ice machine checks for cleanliness. Monthly for ice machine cleaning. The Dietary supervisor/designee will be responsible to see that this is maintained in a workable sanitary condition. Forms: Dish maintenance; 3 compartment sinks; 1 bucket in-service; GFS check out invoice; copy of contract ice machine. This is done as of 3/2/2013.*Copy of policy and procedure is included, tagged</p>	03/02/2013	

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	<p>at that time, indicated all of the sanitizing buckets were filled with the sanitizing solution from the 3 compartment sink. She indicated the facility used quat (quaternary ammonium compound) solution as the sanitizing agent for the sanitizing buckets and the 3 compartment sink. She indicated the sanitizing solution should register at least 200 ppm.</p> <p>On 1/22/13 at 9:05 a.m., the Dietary Manager tested the sanitizing solution in the 3 compartment sink. It registered 100 ppm.</p> <p>On 1/22/13 at 9:10 a.m., the "Temperature and Sanitizer Log" posted near the 3 compartment sink was observed. It indicated the sink sanitizer concentration was not documented for breakfast on 1/22/13.</p> <p>The Policy for "Dish Machine Out of Order" dated 8/25/08, was provided by the Dietary Coordinator on 1/25/13. She indicated the policy was current and that was the policy that was used for the 3 compartment sink and for the sanitizing buckets. The policy indicated, "Cleaning procedure: 1. Clean and sanitize sink before using. 2. Scrap or presoak items in presoak</p>		as F371.				

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	<p>sink before using</p> <p>3. Fill each sink with water</p> <p>4. Test sanitizing solution for proper dilution</p> <p>5. Sink 1: Wash items in clean water. Make sure all traces of food and detergent are gone</p> <p>7. Sink 3: Rinse items in clean water. Make sure all traces of food and detergent are gone</p> <p>8. Sink 3: Sanitize in a solution of chlorine bleach (50 ppm), iodine (12.5 ppm) or quat sanitizer (200 ppm) at a room temperature of 75 degrees Fahrenheit for not less than 1 minute"</p> <p>Interview with the Dietary Coordinator on 1/25/13 at 10:37 a.m. indicated the "Temperature and Sanitizer Log " was not completed on 1/22/13 during the Brief Kitchen Tour.</p> <p>2. During the environmental tour on 01/29/13 from 11 a.m. to 11:45 a.m. with the Director of Maintenance and the Director of Housekeeping present the following was observed:</p> <p>The ice machine in the Main Street Nutritional Pantry was full of ice and had a small amount of a black oily substance on the plastic piece inside of the machine (not touching the ice).</p> <p>At the time of the observation, the</p>						

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	<p>Director of Maintenance indicated the ice machine is leased and the company comes out every month to clean the ice machine.</p> <p>The ice machine in the Elm Court Nutritional Pantry was half full of ice and there was a black substance on the upper inside wall of the machine.</p> <p>At the time of the observation, the Director of Maintenance indicated the ice machine had been cleaned last month. He indicated the ice machine is owned by the facility and it is cleaned every month.</p> <p>During an interview on 01/29/13 at 11:55 a.m., the Director of Maintenance indicated he had no documentation of cleaning the ice machine every month. The Director of Maintenance presented a copy of the cleaning schedule on the contracted ice machine. He indicated there was not a policy on cleaning the ice machine.</p> <p>3.1-(i)(3)</p>				

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F0463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the call system was functioning for 4 of 40 bathroom call lights checked for function. (Residents #4, #43, #48 and #76)</p> <p>Findings include:</p> <p>1. During an observation on 01/22/13 at 4:05 p.m., with the Administrator present, Resident #76's room call light button was pressed, the call light did not ring or become visible on the call light reader board.</p> <p>During an interview at the time of the observation, the Administrator indicated they would try a new cord on the call light.</p> <p>2. During an observation on 1/23/13 at 8:14 a.m., Resident #4's room call light was pressed. The call light did not light up on reader board and did not produce a sound.</p> <p>During an Interview with the Administrator on 1/23/13 at 8:16 a.m.,</p>	F0463	<p>The call light system is fully functional with each resident call light working correctly at this time, especially resident #4, #43, #48 & #76.</p> <p>The call light system has been thoroughly gone over, each room call light checked for proper function.</p> <p>The call light system is checked weekly and call cords and transmitters are checked weekly with as needed repair (battery replacement, call cord replacement) as reported. Staff is to notify maintenance if system problems occur.</p> <p>The maintenance supervisor along with the IT Manager and Administrator are responsible to see that the system is functioning properly to maintain compliance.</p> <p>See form included.</p> <p>This is done as of 2/1/2013.</p>	02/01/2013			

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	<p>he indicated when the call light is turned on there should be a beeping sound to alert staff and the room should be indicated on the electronic reader board.</p> <p>3. During an observation on 01/23/13 at 9:11 a.m., with CNA #5 present, Resident #43's call light was pressed. The call light did not light up on the reader board and did not produce a sound.</p> <p>During an interview at the time of the observation, CNA #5 indicated the call light was not working.</p> <p>4. During an observation on 1/24/13 at 8:40 a.m., with RN #4 present, Resident #48's bathroom light would not activate.</p> <p>During an interview on 01/24/13 at 8:48 a.m., the Director of Maintenance indicated all call lights had been checked and new cords had been ordered and should be at the facility by 12 p.m.</p> <p>During an interview on 1/24/13 at 9:08 a.m., the Director of Maintenance indicated the string around the call light in Resident #48's bathroom had the string wrapped around it so it could not be pulled.</p>				

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F0465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interviews, the facility failed to ensure the residents' environment was clean and in good repair related to, dirty floors and rusty ceiling vents in 1 of 1 kitchens, which has the potential to affect 61 of 61 residents who consume meals at the facility. Also, peeling paint, scrapes on over the toilet commodes, bubbled and peeling plaster, scraped walls, indented section on the floor, rust stains on bathroom shelves, missing tiles, loose baseboards, black substances on tile and walls in the shower, rusted and dirty cabinets, for 2 of 2 Units (Main Street and Elm Court), 2 of 2 shower rooms (Main Street and Elm Court), and 2 of 2 nutritional rooms (Main Street and Elm Court). (Residents #4, #5, #7, #8, #15, #21, #23, #29, #30, #37, #45, #46, #48, #51, #55, #59, #63, #65, #68, and #73)</p> <p>Findings include:</p> <p>1. The following was observed in the facility:</p> <p>01/22/13 at 10:30 a.m., there was</p>	F0465	<p>The commodes have been replaced for residents #46 and #59. The floor has been repaired in resident #48's room. The toilet fixture has also been repaired. The door frame in resident #4's room has been repaired. The wall in resident #73's room has been repaired. The wall in resident #23's room has been repaired. The wall in resident #29's room has been repaired. Repairs in resident #63's room have been completed and include wall repairs and replacement of the over toilet commode. The chipped paint in resident #5's room has been repaired as well as the over toilet commode replaced. The bathroom shelves in the following rooms have been cleaned so as to be free of rust stain: #7, #8, #15, #21, #30, #37, #45, #51, #55, #65 and #68. The Main Street shower has been repaired with new base board and caulking. The Main Street nutritional pantry has been repaired, new cabinets have been installed. The Elm Court nutritional pantry has been cleaned and repainted to provide an acceptable clean surface. Repairs have been made to the Elm Court</p>	03/02/2013	

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	<p>peeling paint and scrapes on the over the toilet commode in Resident #46's and #59's bathroom.</p> <p>During an interview on 01/29/13 from 11 a.m., the Director of Maintenance indicated they had other over the toilet commodes to replace the ones with peeling paint.</p> <p>01/22/13 at 2:46 p.m., there was a three inch in diameter section of the floor near foot of the bed A that was cracked and dented and rust was noted on toilet fixture in Resident #48's room.</p> <p>01/23/13 at 8:13 a.m., there were mars on the door frame of the bathroom and was in need of paint in Resident #4's room.</p> <p>01/23/13 at 8:42 a.m., the plaster on the wall under the window was bubbled in Resident #73's room.</p> <p>01/23/13 at 9:01 a.m., there were scrapes on the wall behind Resident #23's bed.</p> <p>01/23/13 at 9:07 a.m., there were scrapes on the wall behind Resident #29's.</p> <p>01/23/13 at 10:06 a.m., the plaster on</p>		<p>shower unit to include replacement of missing tile and grout cleaning. The door frame outside the shower has also been repaired. Dietary: The oven hood above the stove has been cleaned and is maintained as such. The ceiling vent has been cleaned and painted and is maintained in a presentative state. The floors have been cleaned and the discolored grout is now clean and maintained with special attention to the stove area while cleaning. Weekly rounds are to be conducted so as to observe areas that may require attention. This practice will help to identify and correct areas that require attention. Weekly round outcomes will be given to the department supervisor for follow up and repair as needed. The rounds will include but not be limited to, the Administrator, DON, Environmental Service and Maintenance Supervisor and/or designee to make the weekly rounds and provide corrective action for areas found to be in need of repair/replacement etc... Done as of 3/2/2013.</p>		

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	<p>the wall was bubbled and peeling, there were scrapes on wall behind bed, and commode over the toilet had scraped paint in Resident #63's room.</p> <p>01/23/13 at 11:51 a.m., there were chips in the wall and chipped paint on the commode over the toilet in Resident #5's room.</p> <p>01/23/13 from 8:13 a.m. through 10:04, there were rust stains on the metal shelves under the mirrors in the bathrooms of Residents' #7, #8, #15, #21, #30, #37, #45, #51, #55, #65, and #68.</p> <p>During an interview on 01/29/13 from 11 a.m. to 11:45 a.m., the Director of Housekeeping indicated the shelves are washed out daily when they are cleaned.</p> <p>During the environmental tour on 01/29/13 from 11 a.m. to 11:45 a.m. with the Director of Maintenance and the Director of Housekeeping present, all the above was observed and the following was also observed:</p> <p>There was a black substance on the floor, loose baseboard, and blackness on the caulking and behind the loose baseboard in the Main Street shower room.</p>				

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	<p>At the time of the observation the Director of Maintenance indicated the black on the tile was from the glue from the baseboard.</p> <p>There was a large amount of rust in the cabinet under the sink and a lower cabinet was dirty and sticky in the Main Street nutritional pantry.</p> <p>There was a dirty, rusty, and stickiness of a lower cabinet in the Elm Court nutritional pantry, where unopened packets of briefs were stored and the cabinet under the sink was dirty.</p> <p>There were missing tiles and stained grout in the shower of the Elm Court Unit and the plaster wall by the door frame outside of the shower was cracking and peeling.</p> <p>2. During the Kitchen Sanitation tour on 1/25/13 at 9:51 a.m., the following was observed with the Dietary Coordinator.</p> <p>a. The oven hood above the stove was observed to have splattered areas of grease and debris. The oven hood were in need of cleaning.</p> <p>b. 1 of 4 ceiling vents had rust and was in need of paint or repair.</p>						

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	<p>c. The floor throughout the kitchen had discolored grout and was in need of deep cleaning. The floor tiles behind the stove and the ovens were soiled with dirt and food debris and in were in need of cleaning.</p> <p>Interview with the Dietary Coordinator at the time of the tour, indicated the above areas were in need of cleaning or repair.</p> <p>3.1-19(f)</p>			

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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922			
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F0499 SS=B	<p>483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on record review and interview, the facility failed to ensure all CNA's had valid certifications while employed as a CNA for 1 of 42 CNA's reviewed for certifications. This had the potential to affect 38 residents who resided on 1 of 2 units in the facility. (Main Street and CNA #6)</p> <p>Findings include:</p> <p>During the employee record review on 01/29/13 at 2 p.m., CNA #6 started employment at the facility on 11/19/12. CNA #6's certification indicated the certification expired on 11/10/12.</p> <p>CNA #6's employee file indicated the CNA registry was checked on 11/07/12 prior to hiring the employee.</p> <p>The employee activity report (time clock) indicated CNA #6 worked in the facility as a CNA on November 19, 20, 23, 24, 25, 28, and 29, 2012,</p>	F0499	<p>The C.N.A. cited was terminated from employment within her 90 day introductory period. At the time of her hiring, she had a current C.N.A. certificate.</p> <p>The business office has reviewed all of the C.N.A. certificates and has developed a check list for pre/post hiring to track certification/licenses to assure they are current and renewed as needed to remain current.</p> <p>The business office will maintain a new hire check list to assure that any necessary certificates/licenses are current and valid. Staff will be notified if renewal is needed.</p> <p>This will be the responsibility of the HR/Payroll personnel and review with each new hire and current staff.</p> <p>This is done as of 2/1/2013.</p>	02/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2013
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	<p>December 3, 4, 7, 8, 13, 14, 15, 18, 19, 23, 24, 26, 28, and 31, 2012, and January 1, 4, 5, 6, 8, 9, 14, 18, 19, and 20, 2013.</p> <p>During an interview on 01/29/13 at 3 p.m., Human Resource Director indicated she had just began the position and she had not caught the expired CNA certification. She indicated the past Director of Nursing had hired the CNA. She indicated when she realized the CNA certification had expired, the CNA had been terminated on 01/25/13.</p> <p>During an interview on 01/31/13 at 11:45 a.m., the Restorative Nurse indicated the CNA had only worked on the Main Street unit.</p> <p>3.1-14(s)</p>			