

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/18/2016
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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00198000.</p> <p>Survey dates: April 11, 12, 13, 14, 15 and 18, 2016</p> <p>Facility number: 000365 Provider number: 155423 Aim number: 100287460</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payor type: Medicare: 20 Medicaid: 43 Other: 8 Total: 71</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed by 32883 on 4/21/16.</p>	F 0000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the April 18, 2016 Annual Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on May 2, 2016 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Kimberly Ready Executive Director</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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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's call light was within reach for 1 of 35 residents observed during Stage 1. (Resident #18)</p> <p>Finding includes:</p> <p>On 4/12/16 at 10:24 a.m., Resident #18 was observed in her room seated in a wheelchair at the bedside. The resident's call light was dangling from the lowered side rail and touching the floor.</p> <p>The record for Resident #18 was reviewed on 4/12/16 at 10:30 a.m. The Annual Minimum Data Set (MDS) assessment dated 3/3/16, indicated the resident's Brief Interview for Mental Status (BIMS) score was 12. The resident was cognitively intact for decision making.</p> <p>Interview with CNA #1 on 4/12/16 at</p>	F 0246	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Upon identification, CNA immediately placed call light within resident #18's reach. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Executive Director conducted rounds for all current residents on April 19, 2016 to ensure residents' call lights were within reach. No issues were identified via this audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be re-educated prior to May 18, 2016 by the Staff Development Coordinator and/or designee in relation to placing call light within reach of resident. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Weekly random audits will be completed</p>	05/18/2016

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F 0309 SS=D Bldg. 00	<p>10:25 a.m., indicated the resident was capable of using the call light and she had forgotten to place it within the resident's reach before leaving the room.</p> <p>3.1-3(v)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 4 residents who met the criteria for skin conditions (non-pressure related). (Resident #105)</p> <p>Finding includes:</p>	F 0309	<p>by the facility department managers for the next 6 months on various shifts to observe a minimum of 5 residents to ensure placing call light within residents' reach is maintained. Any issues identified will be immediately addressed and all audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The observed bruises to resident #105's top right hand and between thumb and index finger on left hand will be monitored until healed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility skin audit will be completed by</p>	05/18/2016	

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	<p>On 4/12/16 at 11:21 a.m., Resident #105 was observed with an area of purple/reddish discoloration between his thumb and index finger on his left hand.</p> <p>On 4/15/16 at 8:40 a.m., the resident was observed with purple/reddish bruising to the top of his right hand.</p> <p>The record for Resident #105 was reviewed on 4/13/16 at 3:17 p.m. The resident's diagnoses included, but were not limited to, heart failure, chronic respiratory failure and atrial fibrillation.</p> <p>A Physician's order dated 2/19/16, indicated the resident received 81 milligrams (mg) of Aspirin daily.</p> <p>The care plan dated 4/11/16, indicated the resident was at risk for abnormal bleeding or hemorrhage because he was receiving Aspirin.</p> <p>There was no documentation in the Nursing progress notes on 4/12/16 related to the bruising to the left hand. There was also no "Non-pressure Skin sheet" available for review.</p> <p>Documentation in the Nursing progress notes on 4/15/16 at 4:06 a.m., indicated the resident had an area of small bruising to his right hand related to his heplock</p>		<p>the DON and/or designee on or before May 18, 2016 to ensure any identified areas of bruising are assessed and monitored along with proper documentation and follow up per facility policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education will also be provided to licensed nurses by the DON and/or designee by May 18, 2016 related to areas of bruising assessment and monitoring along with proper documentation and follow up per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DON and/or designee will perform a weekly audit for 6 months on a minimum of 10 residents to ensure weekly skin checks are completed, along with proper documentation and follow up as per facility policy. Validation of this audit will occur via visual inspection of the resident. Any issues will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits.</p>	

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	<p>(an intravenous access site). There was no further documentation on 4/15/16 related to the bruising of the right hand.</p> <p>The Nursing progress notes for 4/16/16 and 4/17/16 were reviewed. There was no documentation related to the bruising to the resident's right hand.</p> <p>An entry in the Nursing progress notes on 4/18/16 at 4:18 a.m., indicated there was no documentation related to the bruising.</p> <p>A "Non-pressure Skin sheet" had not been initiated for the bruising to the top of the resident's right hand.</p> <p>Interview with the Interim Director of Nursing on 4/15/16 at 2:50 p.m., indicated when a bruise or non-pressure skin area was observed, a yellow non pressure skin sheet was to be initiated.</p> <p>Interview with the Staff Development Nurse on 4/18/16 at 12:02 p.m., indicated there was no specific policy related to non-pressure skin areas but it was facility protocol to complete weekly skin assessments. If non-pressure skin areas were observed, a "Non-pressure Skin sheet" was completed.</p> <p>3.1-37(a)</p>			

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F 0318 SS=D Bldg. 00	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure each resident received appropriate treatment for contractures to prevent further decrease in Range of Motion (ROM) for 1 of 3 residents reviewed for ROM of the 9 who met the criteria for ROM. (Resident #54)</p> <p>Finding includes:</p> <p>On 4/13/16 at 9:06 a.m., 10:31 a.m., 11:51 a.m., and on 4/14/16 at 9:43 a.m., 11:18 a.m., and 12:27 p.m., Resident #54 was observed sleeping in the hallway in her geri chair (a high back wheel chair) in front of the Nurses' station. The resident had contractures (limited movement) to both hands and her left knee. There was a palm protector observed on the resident's right hand. There was no palm protector observed on the resident's left</p>	F 0318	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Upon identification, staff member located resident #54's adaptive devices and properly applied them on resident. In addition, clarification order was received on April 18, 2016 for resident #54's left knee extension brace. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full audit of current residents' will be completed on or before May 18, 2016 by the DON and/or designee to ensure residents with contractures receive the necessary treatment to prevent decline related to range of motion. Any identified issues will be referred to therapy for further evaluation and treatment. What measures will be put into place or</p>	05/18/2016

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	<p>hand, nor a left sided foam elbow splint or knee extension brace to her left leg.</p> <p>On 4/13/16 at 11:59 a.m., observation with LPN #2 indicated the resident did not have a left palm protector, left foam elbow splint, or left knee extension brace in place.</p> <p>The record for Resident #54 was reviewed on 4/13/16 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension, major depression, hemiplegia and hemiparesis (weakness/paralysis), osteoarthritis, cognitive age related decline, contractures, muscle wasting and atrophy.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 1/26/16, indicated the resident had ROM limitations on both sides of the upper and lower extremities.</p> <p>A Care Plan dated 2/9/16, indicated the resident had upper and lower extremity contractures with left hemiplegia. The approaches included, but were not limited to, provide adaptive/safety equipment such as left knee brace, left hand palm protector, and left wedge elbow splint.</p> <p>Review of the 4/2016 Physician's Order Summary (POS), indicated to apply the</p>		<p>what systemic changes will be made to ensure that the deficient practice does not recur: DON and/or designee will complete staff competencies to the Restorative CNAs related to range of motion on or before May 18, 2016. In addition, re-education will be provided by the DON and/or designee on or before May 18, 2016 to Restorative nursing staff (CNAs and Restorative Nurse) related to the Restorative program's policy and procedures along with proper documentation and necessary forms. Re-education will be provided by the DON and/or designee to the nursing staff on or before May 18, 2016 in regards to following residents' plan of care and care directives in relation to applying adaptive/safety devices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DON and/or designee will review the weekly Restorative meeting minutes/notes to ensure Restorative nursing staff reviewed resident both on caseload as well as any other resident identified as having potential for decline in range of motion along with ensuring necessary orders, treatment administration record, plan of care, and care directives are updated as needed. Weekly random audits will be completed by facility department managers for the next 6 months on various shifts to observe a minimum of 5</p>	

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F 0322 SS=D Bldg. 00	<p>left knee extension brace for 6 hours between 7:00 a.m., and 1:00 p.m. Bilateral palm protectors and a left soft foam splint to the elbow were to be worn at all times.</p> <p>Review of the Restorative Note dated 4/3/16, indicated staff were applying the left knee brace at 7:00 a.m. and taking it off at 11:00 a.m.</p> <p>Interview with CNA #2 on 4/14/16 at 1:57 p.m., indicated she had gotten the resident up that morning and she only applied a palm protector to the resident's right hand.</p> <p>Interview with the Interim Director of Nursing on 4/14/16 at 3:24 p.m., indicated the resident should have been wearing the proper adaptive devices and she would clarify the Physician's Orders.</p> <p>3.1-42(a)(2)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p>		<p>residents to validate care directives are followed to ensure residents receive appropriate treatment for contractures to prevent further decrease in range of motion as per resident's plan of care. Any issues will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits.</p>		

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	<p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure placement was checked properly prior to the administration of medications through a Gastrostomy tube (a tube inserted into the stomach used for nutrition and medication) for 1 of 1 residents observed during medication pass with a Gastrostomy tube. (Resident #52)</p> <p>Finding includes:</p> <p>On 4/15/16 at 2:01 p.m., LPN #1 was observed preparing and pouring medications for Resident #52. At that time, the LPN indicated the resident had a Gastrostomy tube so she crushed each medication individually and placed them into separate plastic cups. Prior to the administration of the medication, LPN #1 indicated she would be checking for proper Gastrostomy tube placement. She</p>	F 0322	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:After identification of improperly checking placement of gastrostomy tube for Resident #52, placement was re-checked properly as per facility policy. Assessment of resident showed no negative results from deficient practice. Education and competency of LPN #1 was performed on 4/14/2016 by Staff Development Coordinator. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:All other residents receiving nutrition via a gastrostomy tube have the potential to be affected by this deficient practice. Each of these resident's gastrostomy tube placement was verified by licensed nursing as per facility. Assessment of these residents</p>	05/18/2016

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	<p>drew up 5 cubic centimeters (cc's) of water into a syringe and placed the tip of the syringe into the opening of the Gastrostomy tube. The LPN then placed her stethoscope on the resident's abdomen and pushed the 5 cc's of water into the tube. The LPN proceeded to flush the tube and administer the medications.</p> <p>Interview with LPN #1 on 4/15/16 at 2:22 p.m., indicated she had thought the facility's policy was to use a 5 cc water bolus rather than air bolus for checking for placement of the Gastrostomy tube. She indicated the policy had been changed about a year ago.</p> <p>The current and undated Feeding Tube-Instilling Medication policy provided by the Interim Director of Nursing on 4/15/16 at 2:45 p.m., indicated Medications were administered appropriately and safely when the resident had a feeding tube. The procedure was to attach the syringe to the end of the tube and insert 20 cubic centimeters (cc's) of air, check for placement and patency by auscultation. If the tube was not adequately placed, do not give the medication and do not flush with water, but adjust placement of feeding tube or insert a new one.</p>		<p>showed no negative results. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Medication Administration/Placement Verification Competencies via Gastrostomy tube will be completed with each licensed nurse by May 18, 2016 with return demonstration observed by DON and/or designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:DON and/or designee to randomly observe 2 nurses weekly on various shifts for the next 6 months on medication administration/placement verification pass via Gastrostomy tube to ensure checking placement properly prior to administration of medications. Any issues will be immediately addressed and all audit results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits.</p>				

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F 0329 SS=D Bldg. 00	<p>Interview with the Interim Director of Nursing on 4/15/16 at 2:50 p.m., indicated the facility's policy was to check with an air bolus not a water bolus.</p> <p>3.1-44(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a Gradual Dose Reduction (GDR) for an antipsychotic medication was attempted</p>	F 0329	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:A care plan meeting took place on April 27,	05/18/2016	

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	<p>at least one time per calendar year for 1 of 5 residents reviewed for unnecessary medications. (Resident #80)</p> <p>Finding includes:</p> <p>On 4/13/16 at 9:22 a.m., and on 4/14/16 at 8:30 a.m., Resident #80 was observed sitting in a wheelchair. At those times, there were no behaviors observed by the resident.</p> <p>The record for Resident #80 was reviewed on 4/14/16 at 9:37 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, dementia, insomnia, repeated falls, and major depressive disorder.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 1/20/16, indicated the resident had short and long term memory problems. The resident was severely impaired for decision making and was not alert and oriented. The resident displayed no mood problems, had no indicators of psychosis, and no behaviors. The resident was coded as wandering throughout the facility every day. The resident received an antipsychotic medication, an antianxiety medication, and an antidepressant medication consecutively for 7 days.</p>		<p>2016 with Resident #80's family member, physician, nurse practitioner, and facility interdisciplinary team. At the end of this meeting, all parties were in agreement to move forward with a gradual dose reduction of Resident #80s Seroquel medication from 25 mg TID to 25 mg BID along with Seroquel 12.5 mg daily. In addition, Resident #80 receives ongoing monitoring for antipsychotic medication use as per physician orders. Resident's plan of care was reviewed with staff and education provided related to importance of documentation of antipsychotic medication use and monitoring. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit will be completed prior to May 18, 2016 by the DON and/or designee related to those residents requiring administration and monitoring of antipsychotic medications to ensure gradual dose reductions for antipsychotic medications are attempted as per facility policy. Any identified issues will be immediately addressed as per facility protocol. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education will be provided to licensed nurses and the social service director by the</p>				

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	<p>The current and updated plan of care dated 1/2016, indicated the resident had the potential for discomfort and side effects related to the use of psychotropic medication and the resident was also combative with care at times. The Nursing approaches were to ask the Physician to review medications for possible dose reduction as needed.</p> <p>Physician Orders dated 3/11/15 and on the current 2016 recapitulation, indicated Seroquel (an antipsychotic medication) 25 milligram (mg) three times a day (tid) at 6:00 a.m., 3:00 p.m., and 7:30 p.m. for psychosis.</p> <p>A behavior note documented by the Nurse Practitioner dated 3/10/16, indicated the resident was restless and propelling herself on the unit. The resident was easily redirected. The resident was observed reaching out and touching others passing her. A CNA indicated the resident was not as combative with care, and it happened infrequently. The Social Service Director reported the resident displayed some behaviors of aggressive grabbing of others, verbally aggressive language and wheelchair pacing. The resident's daughter disagreed with a Seroquel reduction ordered from tid to twice a day (bid) in June 2015. The recommended</p>		<p>DON and/or designee by May 18, 2016 in regard to documentation and monitoring of antipsychotic medication use related to attempting gradual dose reductions as per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DON and/or designee will review the weekly behavior management minutes along with performing weekly audits of a minimum of 5 residents requiring use of antipsychotic medication for the next 6 months to ensure gradual dose reductions are attempted as per facility policy. Any issues identified will be immediately addressed and all audit results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits.</p>		

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	<p>treatment plan was to discontinue Seroquel 25 mg tid and start Seroquel 25 mg bid.</p> <p>A Social Service Progress note dated 3/11/16, indicated a behavior meeting was held. A GDR for Seroquel was due at that time. Recommend to reduce Seroquel 25 mg tid to Seroquel 25 mg bid.</p> <p>Nurse's notes dated 3/11/16 at 2:19 p.m., indicated a GDR order was received to reduce the Seroquel from tid to bid. The resident's daughter was notified and adamantly refused to have the medication reduced. The resident's Physician was notified and orders were received to keep the Seroquel at three times a day.</p> <p>Another Social Service Progress note dated 3/11/16 at 3:07 p.m., indicated Social Service was informed the resident's daughter had refused the GDR for the Seroquel. The Social Service Director (SSD) called the resident's daughter regarding the refusal. The daughter adamantly stated that she did not want the GDR. The SSD tried to explain the reason for the GDR, and the resident's daughter again stated NO and hung up the phone .</p> <p>The behavior monitoring record for</p>						

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	<p>1/2016 was reviewed. The resident's behaviors were wandering in other rooms on 1/9/16, 1/13/16 and 1/15/16. The resident's behaviors of socially inappropriate and touching others were displayed on 1/9/16, and 1/11/16. There were no further behaviors noted for that month.</p> <p>The behavior monitoring record for 2/2016 was reviewed. The resident's behaviors were wandering in other rooms on 2/6/16. The resident's behaviors of socially inappropriate and touching others were displayed on 2/2/16, 2/4/16, 2/6/16, and 2/12/16. There were no further behaviors noted for that month.</p> <p>The behavior monitoring record for 3/2016 was reviewed. The resident's behaviors of socially inappropriate and grabbing at staff were displayed on 3/16/16, 3/17/16, 3/20/16, 3/21/16, and 3/23/16. There were no further behaviors noted for that month.</p> <p>Interview with the SSD on 4/14/16 at 11:00 a.m., indicated she had talked to the resident's daughter numerous times and was constantly told not to touch or change her mother's Seroquel. She indicated she had repeatedly tried to explain to the resident's daughter but she would not listen to her.</p>						

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F 0356 SS=C Bldg. 00	<p>3.1-48(b)(2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>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"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <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"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <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>			

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	<p>Based on observation and interview, the facility failed to ensure the daily staffing pattern was posted at the Main Entrance at the beginning of the morning shift.</p> <p>Finding includes:</p> <p>On 4/11/16 at 8:55 a.m., the facility staffing sign posted at the Main Entrance was dated for Saturday 4/9/16. At 9:28 a.m., the facility staffing sign was still dated 4/9/16.</p> <p>Interview with the Administrator on 4/18/16 at 11:30 a.m., indicated the day shift started at 6:00 a.m., and the facility staffing sheet should be posted at that time and be current.</p> <p>3.1-17(a)</p>	F 0356	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Upon identification by staff on April 11, 2016, the daily staffing pattern posted in the main entrance of facility was updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: No residents were directly impacted by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director and/or designee to re-educate nursing staff by May 18, 2016 to ensure the daily staff pattern is updated on daily staffing board prior to the start of morning shift. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Executive Director and/or designee will audit the availability of the posted nurse staffing information to ensure the daily staffing pattern is posted as facility protocol and document the results. This audit will take place daily including weekends for the next 6 months. Any issues will be immediately addressed with staff responsible and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of</p>	05/18/2016	

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F 0441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p>		correction developed and implemented as deemed necessary. QA will determine the need for further audits.	

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	<p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control was maintained related to the storage of urinals, wash basins, and bed pans. The facility also failed to ensure uncontained soiled linens were not left lying on the floor on 2 of 2 units. (The North and South units) (Resident #B)</p> <p>Findings include:</p> <p>1. On 4/12/16 at 8:39 a.m., Room 205 was observed with two dirty hospital gowns, three wet wash cloths and two towels on the floor by a chair. At that time, there was also a urinal observed on the floor with no lid and full of urine by Resident #B's bed. There were two residents who resided in the room.</p> <p>On 4/12/16 at 8:42 a.m., Resident #B was observed sitting by the Nurses' station. At that time, the resident was observed with an indwelling foley catheter.</p> <p>Interview with the Staff Development Nurse on 4/15/16 at 2:36 p.m., indicated the linens should not have been left on the floor. She further indicated Resident #B had a foley catheter and was not</p>	F 0441	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The urinals in room 205 (Resident #B), bathroom of room 102, and room 223 have been discarded and replaced with new urinals that are now labeled and stored in a sanitary manner within residents' rooms in accordance with facility policy by the DON and/or designee. The wash basins in the bathroom of room 102 and on the counter top in room 201 have been discarded and replaced with new wash basins that are now labeled and stored in a sanitary manner within the residents' rooms in accordance with facility policy by the DON and/or designee. The bedpan in room 105 has been discarded and replaced with a new bedpan that is now labeled and stored in a sanitary manner with the resident's room in accordance with facility policy by the DON and/or designee. Upon identification by CNA of uncontained soiled linens lying on the floor in room 205, staff member properly removed items from resident's room as per facility policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Per</p>	05/18/2016	

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	<p>capable of emptying his own catheter. She further indicated the CNA's would have had to do that for him.</p> <p>The current and undated Bed Making policy provided by the Staff Development Nurse on 4/18/16 at 9:35 a.m., indicated "The following procedure will be adhered to when performing any type of bed making. Do not place soiled linen on the floor. As you remove it, place it into the container you are using for soiled linen/laundry."</p> <p>2. During the Environmental Tour on 4/15/16 at 1:30 p.m., with the Administrator, Maintenance Supervisor, and the Housekeeping Supervisor the following was observed:</p> <p>North Unit</p> <p>a. There was a pink wash basin stored on the floor and a urinal hanging from the toilet seat riser in the bathroom of Room 102, both were uncovered. Four residents shared this bathroom.</p> <p>b. There was a bedpan stored on the chair next to the bed and a urinal stored on the bedside table in Room 105, both were uncovered. Two residents shared this room.</p> <p>3. South Unit</p>		<p>completion of room audits by Executive Director, any unlabeled resident care equipment was immediately discarded and new items redistributed. No issues were identified via this audit with uncontained soiled linens lying on the floor. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility staff will be re-educated by the Staff Development Coordinator and/or DON by May 18, 2016 relating to proper storage of wash basins, urinals, and bed pans along with not placing uncontained soiled linen on the floor prior to removing from residents' room as per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: For the next 6 months, department managers to complete weekly rounds on various shifts for 5 resident rooms to validate infection control is maintained related to the storage of wash basins, urinals, and bed pans along with ensuring uncontained soiled linens are not left lying on the floor as per facility policy. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed</p>		

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F 0465 SS=E	<p>a. There was a pink wash basin stored on the counter top uncovered in Room 201. Two residents shared this room.</p> <p>b. There was a uncovered urinal stored on the bedside table in Room 223. Two residents shared this room.</p> <p>Review of the current and undated Offering And Removing The Urinal Policy provided by the Staff Development Nurse on 4/18/16 at 9:35 a.m., indicated ..."Clean the urinal. Wipe dry with a clean paper towel. Discard paper towel in waste paper receptacle. Store the urinal. Do not leave it in the bathroom or on the floor." Infection control measures were to clean and store equipment after use.</p> <p>Interview with the Administrator at the time, indicated the above were improperly stored.</p> <p>3.1-18(b)(1)</p>		necessary. QA will determine the need for further audits.		
	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR				

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Bldg. 00	<p><b>TABLE ENVIRON</b></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 interview, the facility failed to provide a functional and sanitary environment related to exposed insulation, dried spillage on fixtures, marred walls and doors, and peeling paint on 2 of 2 units throughout the facility. (The North and South Units)</p> <p>Findings include:</p> <p>During the Environmental tour with the Administrator, Maintenance Supervisor, and Housekeeping Supervisor on 4/15/16 at 1:30 p.m., the following was observed:</p> <p>1. North Unit</p> <p>a. There was exposed insulation underneath the heat register in Room 100. Two residents shared this room.</p> <p>b. There was dried spillage on the call pad of bed B as well as on the bottom of the base board next to the heat register in Room 112. Two residents shared this room.</p> <p>c. The wall was marred behind the head of bed A in Room 113. Two residents shared this room.</p>	F 0465	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The exposed insulation underneath the heat register in room 100 has been covered. The call pad of bed B as well as the bottom of the base board next to the heat register in room 112 has been replaced. The marred walls behind the head of beds in room 113A, 117A, and 213A have been repaired, along with the peeling paint underneath the over bed light above bed B in room 221. The bathroom ceiling vent was cleaned in room 115. In addition, the bathroom door frame in room 213 was repaired. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Environmental rounds have been completed by maintenance department and plan has been put in place to address identified issues and/or items to be replaced on and/or before May 18, 2016. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will include identified areas in the current preventive maintenance program and</p>	05/18/2016			

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	<p>d. The bathroom ceiling vent was dusty in Room 115. Four residents shared this bathroom.</p> <p>e. The wall was marred behind the head of bed A in Room 117. Two residents shared this room.</p> <p>2. South Unit</p> <p>a. The wall was marred behind the head of bed A in Room 213. The bathroom door frame was also chipped and marred. Two residents shared this room.</p> <p>b. There was peeling paint underneath the over bed light above bed B in Room 221. Two residents shared this room.</p> <p>Interview with the Maintenance Supervisor at the time, indicated all of the above items were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>		<p>conduct routine resident room rounds according to the facility protocol. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Department managers to conduct resident room observation 5 times weekly for the next 6 months and will report any maintenance related issues to the maintenance department upon identification of any concerns. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits.</p>		