

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155104	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN 47710
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey Dates: January 14, 15, 16, 21, 22, 23, 2014</p> <p>Facility number: 000043 Provider number: 155104 AIM number: 100290960</p> <p>Survey team: Barbara Fowler, RN, TC Denise Schwandner, RN Diana Perry, RN Diane Hancock, RN 1/14, 1/15, 1/21, 1/22, 1/23/14 Anna Villain, RN 1/14/14, 1/15/14, 1/16/14</p> <p>Census bed type: SNF: 19 SNF/NF: 129 Total: 148</p> <p>Census payor type: Medicare: 30 Medicaid:70 Other:48 Total: 148</p> <p>These deficiencies also reflect state findings cited in accordance with</p>	F000000	<p>F0000 This Plan of Correction is submitted under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The Submission of the Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Furthermore, we request this2567 (Plan of Correction) serve as our credible allegation of compliance. We respectfully request paper compliance on the Plan of Correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>410 IAC 16.2.</p> <p>Quality review completed on January 29, 2014, by Jodi Meyer, RN</p>			

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F000159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review the facility failed to ensure Medicaid resident were notified when personal funds account balances were within 200.00 dollars of account eligibility for 3 of 3 residents who exceeded the resource limit for 19 residents reviewed. (Resident's #106, #109, #84)</p> <p>Findings include:</p> <p>On 1/16/14 at 9:58 a.m., the "Trust Transaction History" provided by the BOM (Business Office Manager) was reviewed. The "Trust Transaction History" dated 12/1/13 through 12/31/13, indicated Resident #106, #109, #84 resident's account balances were within the 200.00 dollars of account eligibility.</p> <p>On 1/16/14 at 10:05 a.m., interviewed the BOE (Business Office Employee) #1. The BOE #1</p>	F000159	<p>F0159 FACILITYMANAGEMENT OF PERSONAL FUNDS Immediate Action – The Administrator, C.F.O., and Billing Office personnel reviewed the current policies related to Management of Personal Funds to ensure that the policy covers the regulatory requirements. Upon review of the Policy it was determined that the Policy meets all regulatory requirements. Review of Residents - The current balance reports of all residents were reviewed, all residents were within the required \$200 resource limitation. Corrective Action – The Administrator, C.F.O., and the Billing Office Personnel examined the procedural processes related to our policy and installed changes in our notification process to ensure that any resident's account that reaches \$200less than the SSI resource limit for one person, such resident or responsible party will be notified. This included revising the Resident's Personal Funds Policy and Procedure. This procedural change was instituted on January 23, 2014. All Business Office</p>	02/22/2014			

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	<p>indicated Medicaid residents were notified of the account balances within 200.00 dollars of account eligibility quarterly. BOE #1 indicated the last notifications were sent in October of 2013.</p> <p>On 1/16/14 at 1:26 p.m., interviewed the BOM. The BOM indicated Medicaid residents were only notified of the account balances within 200.00 of account eligibility quarterly.</p> <p>On 1/21/14 at 11:50 a.m., the Resident's Personal Funds Policy, provided by the Administrator, indicated the facility would notify residents participating in Medicaid when the amount of the resident's account reaches \$200 less than the state/federal resource limit.</p>		<p>Personnel will be in serviced on revised P&P. Monitoring- The Administrator will perform quarterly reviews of the resident account fund generally, and specifically to include review of performance within regulations and policies regarding notifications. This process will be ongoing.</p>		

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F000160 SS=D	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on interview and record review the facility failed to ensure the family of a deceased resident were notified within 30 days of the residents personal funds account for 2 out of 2 residents who expired with personal funds accounts. (Resident # 219, #6)</p> <p>Findings include:</p> <p>On 1/16/14 at 9:58 a.m., the "Trust Transaction History" provided by the BOM (Business Office Manager) was reviewed. The "Trust Transaction History" dated 12/1/13 through 12/21/13, indicated Resident #6 still had an active personal funds account. Resident #6 had expired on 11/28/13.</p> <p>On 1/16/14 at 1:26 p.m., the letters to notify residents and/or family members of personal funds account balances were reviewed. Resident #219 letter to the resident's power of</p>	F000160	F0160 CONVEYANCE OFPERSONAL FUNDS UPON DEATH Immediate Action – As explained to the surveyors at the time of survey, the local bank wherein the resident accounts are maintained, such bank had instituted procedures related to 'freezing' the individual accounts of residents who had died. This 'freezing' process was related to the banks interpretation of the probate laws and rules for Vanderburgh County, Indiana, as related to an 'individuals' account. After receiving notification from the ISDH the affected resident's families were notified. Review of Residents – This regulation pertains to conveyance of residents funds upon death within 30 days. All families of residents, who have expired at this facility, have received any monies due. Corrective Action - We have met with the bank and are in the process of converting the status of the resident fund accounts from 'individual' accounts to a general account and such conversion will not subject the resident funds account money to the banks processes related to	02/22/2014

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F000242 SS=D	<p>attorney was dated 9/20/13.</p> <p>On 1/16/14 at 1:26 p.m., interviewed the BOM. The BOM indicated letters to notify family members of deceased residents personal funds account balances were only sent quarterly. The BOM indicated Resident #219 had expired on 7/14/13.</p> <p>3.1-6(h)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview, record review, and observation, the facility failed to ensure resident's choices were honored for bathing preferences in 2 of 4 residents in a total sample of 27 residents reviewed. (Resident #141,</p>	F000242	<p>probate rules and laws. This conversion process will allow us the ability to convey within 30 days the resident's funds, and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. This process will be completed by February 14, 2014. This process included revising the Resident's Personal Funds Policy and Procedure. All Business Office Personnel will be in serviced on revised P&P. Monitoring- The Administrator will include review of this specific process in the quarterly review of the overall Resident Personal Funds program. This process will be on going.</p> <p>F0242 SELF-DETERMINATION-RIGHT TO MAKE CHOICES Immediate Action – Upon notification from ISDH residents #141 and #51 were interviewed to determine preferences of tub, shower, sponge bath or bed bath.</p>	02/22/2014	

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	<p>Resident #51)</p> <p>Findings include:</p> <p>1. During an interview on 1/15/14 at 11:14 a.m., Resident # 141 indicated she had been refusing to take a shower because the water was too cold. Resident #141 indicated she preferred to take tub baths but she had never received or had been offered a tub bath since being admitted to the facility.</p> <p>Resident #141's son was visiting with the resident and also indicated the resident had always taken a tub bath at home but had never been offered a tub bath at the facility.</p> <p>During record review on 1/16/14 at 11:00 a.m., Resident #141 had a BIMS (Brief Interview for Mental Status) score of 14, indicating minimal mental impairment. A care plan dated 2/21/13 indicated it was very important for the resident to be able to choose whether she received a tub bath, shower, sponge bath, or bed bath.</p> <p>The CNA (certified nursing assistant) assignment sheet obtained on 1/16/14 at 1:03 p.m., indicated Resident #141 was an</p>		<p>Resident #141 bath preference was updated to reflect tub bath. Resident #151 bath preference was updated to reflect daily shower. Review of Residents – Utilizing the Review of Residents form all residents were interviewed to determine bath preferences and number of times a week they prefer to bathe. Shower/bath lists updated to reflect changes. Corrective Action – After initial interview of all residents to determine their preferences the residents will be interviewed at least quarterly in order to update their bathing preferences. FORMCMS-20050 RESIDENT INTERVIEW & RESIDENT OBSERVATION will be utilized for this interview. Monitoring– During weekly High Risk Meetings the UD/Designee will review results of interview of resident in regards to their preferences. Resident Care Plans will be reviewed and updated when necessary. These assessments will coincide with the MDS schedule. This process will continue for a minimum of 12 months.</p>		

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	<p>assist bath.</p> <p>CNA documentation of bathing for residents, reviewed on 1/22/14 at 9:35 a.m., indicated Resident #141 had not received a tub bath from 12/22/13 through 1/22/14.</p> <p>During an interview on 1/22/14 at 9:33 a.m., LPN (licensed practical nurse) #1 indicated the facility did not have a tub for bathing.</p> <p>During observation of the shower rooms on 1/22/14 at 9:43 a.m., bathtubs were located in each of the shower rooms on the Horizon and Harbor units. The Horizon unit was observed to have a walk-in tub for bathing and the Harbor unit was observed to have a whirlpool bathtub.</p> <p>During an interview on 1/22/14 at 9:52 a.m., LPN #1 indicated the bathtub on the Harbor unit was no longer operational.</p> <p>During an interview on 1/23/14 at 9:00 a.m., the DoN (Director of Nursing) indicated the tub on the Horizon's units was operational at the present time, but maintenance was going to check to see what parts may be needed to repair the</p>						

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	<p>tub on the Harbor unit.</p> <p>2. During an interview on 1/15/14 at 9:21 a.m., Resident #51 indicated she would like a shower everyday. Resident #51 indicated she received showers on Mondays and Thursdays only .</p> <p>On 1/22/14 at 9:15 a.m. Resident #51's record was reviewed. A Minimum Data Set assessment, dated 12/20/13, indicated a BIMS (Brief Interview for Mental Status) score of 15 of 15 which indicated the resident was cognitively intact.</p> <p>A care plan, dated 12/20/13, indicated Resident #51 required assistance with bathing, shower and bath. The care plan further indicated Resident \$51 received a shower 2 times a week with assistance.</p> <p>During an interview on 1/22/14 at 9:26 a.m., LPN #1 indicated residents could have showers whenever they wanted. LPN #1 was observed to change the shower assignment sheet to indicate Resident #51 was to receive a shower daily.</p> <p>The bathing shower care sheet was</p>						

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F000309 SS=D	<p>reviewed on 1/22/14 at 9:45 a.m. The bathing shower care sheet for December 22,2013 through January 22,2014, indicated Resident # 51 received a shower 2 times per week.</p> <p>During an interview on 1/22/14 at 10:36 a.m., CNA #1 indicated that residents can have a shower or bath anytime they wanted.</p> <p>3.1-3(u)(3)</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 record review and interview, the facility failed to ensure 1 of 1 resident sampled who received dialysis services had the access site checked to ensure patency. (Resident #218)</p> <p>Finding includes:</p> <p>Resident #218's clinical record was reviewed on 1/22/14 at 8:44 a.m.</p>	F000309	F0309 PROVIDECARE/SERVICES FOR HIGHEST WELL BEING DIALYSIS Immediate Action – Upon notification form ISDH resident #218 chart was reviewed. This resident was discharged on 12/19/13. Review of Residents – Currently there are no resident in the facility with shunts or receiving Dialysis Corrective Action – Admission Audit updated to include 'Any dialysis fistulas – obtain orders for	02/22/2014	

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	<p>The resident was admitted to the facility on 12/27/13 with diagnoses including, but not limited to, cholelithiasis (gall bladder disease) with surgery and drain tube, hypertension, end stage renal disease, diverticulitis and pneumonia.</p> <p>The resident received dialysis services outside of the facility on Mondays, Wednesdays, and Fridays. A care plan was in place for care of the dialysis resident. No date was indicated on the care plan other than a date when the standardized care plan was developed, 2/06. interventions included, but were not limited to, "Monitor bruit as ordered." There were no specific physician's orders for monitoring of the bruit.</p> <p>On 1/22/14 at 9:50 a.m., LPN #2 was interviewed regarding care of Resident #218. She indicated she did care for the resident. She indicated the resident had an AV shunt in her left upper arm for dialysis access. She indicated the resident had several old shunts that were bad, or unusable, but the one in the left upper arm was used. She was asked about procedures the facility used with the dialysis shunts.</p>		<p>dressing, monitoring bruit/thrill. Care Plan and Place on TAR' Created Policy & Procedure for 'Care of the Dialysis Resident' Updated Care Plan for ESRD. Nurses will receive in-service for revised Admission Audit, P&P for Care of the Dialysis Resident and updated Care Plan for ESRD. Monitoring- The Unit Director/Designee will review Admission Assessment of each Dialysis patient. Utilizing the Admission Audit the UD/Designee will ensure that the appropriate orders have been placed on TAR and Care Planned. This process will be on-going.</p>		

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	<p>She indicated she checked for the bruit daily and after dialysis checked the site for bleeding. She indicated the information would be documented on the treatment record.</p> <p>Resident #218's treatment record for January, 2014 was reviewed on 1/22/14 at 10:15 a.m. The treatment record lacked any entry to monitor the resident's shunt site. Review of the nurses' progress notes at that time indicated only one note regarding a thrill and bruit being present, on 12/30/13 at 10:05 p.m.</p> <p>The resident was discharged on 1/16/14 to independent living apartment.</p> <p>The Director of Nurses indicated, on 1/23/14 at 1:15 p.m., there was no specific policy for checking access sites; they were to follow the care plan and get a specific order for how often to check for patency.</p> <p>3.1-37(a)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 interview, observation, and record review, the facility failed to provide adequate monitoring of pain medication for 1 of 5 residents in a total sample of 40 residents reviewed for unnecessary medications and 1 of 7 residents reviewed for pain management in a total sample of 27 residents. (Resident #141, Resident #123)</p>	F000329	F0329 DRUG REGIMENIS FREE FROM UNNECESSARY DRUGS – ADEQUATE MONITORING OF PAIN MEDICATION Immediate Action – upon notification from ISDH residents #123 and #141 were interviewed. Both residents denied any complaints of pain at that time. Review of Residents – Utilizing the Review of Residents form an audit of all residents who receive pain medication was completed to determine if they	02/22/2014			

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	<p>Findings include:</p> <p>1. During an interview on 1/15/14 at 11:17 a.m., Resident #141 indicated she had generalized pain which her pain medication did not always relieve.</p> <p>An observation, on 1/15/14 at 11:17 a.m., indicated Resident #141 to be sitting in her wheelchair in the main lobby visiting with her son. Resident #141 denied any complaint of pain at that time.</p> <p>An observation, on 1/21/14 at 1:30 p.m., indicated Resident #141 to be sitting in her wheelchair in her room. Resident #141 indicated she was not having any pain.</p> <p>Resident #141's record was reviewed on 1/16/14 at 11:00 a.m. Resident #141 had a diagnosis including, but not limited to, osteoarthritis.</p> <p>Resident #141 had a physician's order, dated 5/11/11 for APAP 500 mg tablet 1 po (by mouth) every 4 hours prn (as needed) for pain.</p> <p>Resident #141 had a physician's order, dated 8/12/13, for Lortab</p>		<p>were adequately monitored for effectiveness of medications. No residents were adversely affected by this action. Corrective Action – Revised Pain Management Policy & Procedure. Wong-Baker Faces Pain Rating Scale reviewed, this scale will be placed in MAR for nurse's reference. Created new PRN PAIN MEDICATION NURSEASSESSMENT FORM. This form will be utilized by nurse to provide adequate monitoring of pain medication. Nurses and QMA's will receive in servicing on revised Pain Management P&P, review of Wong-Baker Pain Rating Scale and the new PRN PAIN MEDICATION NURSE ASSESSMENT FORM. MONITORING– Monthly the UD/Designee will perform random checks of MAR and PRN PAINMEDICATION NURSE ASSESSMENT FORM. This process will continue for a minimum of 12 months.</p>				

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	<p>5/500 tab 1/2 po every 4 hours prn for pain.</p> <p>Resident #141's BIMS (Brief Interview for Mental Status) assessment, dated 9/24/13, indicated the resident had minimal mental impairment.</p> <p>Resident #141's MARs (Medication Administration Records) was reviewed on 1/22/14 at 1:45 p.m. A MAR, dated 9/1/13 - 9/30/13, indicated the resident had received Lortab 5/500 tablet 1/2 po (orally) on 9/17/13 at 8:00 p.m. for "pain to legs, burn." The follow-up on 9/17/13 at 8:30 p.m., indicated the medication was "helpful."</p> <p>A MAR, dated 10/1/13 - 10/31/13 and reviewed on 1/22/14 at 1:45 p.m., indicated Resident #141 had received Lortab 5/500/ tablet 1/2 po (orally) on 10/12/13, 10/13/13, 10/16/13, and 10/19/13. The MAR indicated the medication was given for Resident #141's legs with follow-ups being documented as "effective."</p> <p>A MAR, dated 11/1/13 - 11/30/13 and reviewed on 11/22/14 at 1:45 p.m., indicated Resident #141 had received APAP 500 mg po at 8:20</p>						

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	<p>p.m. for a headache. The reassessment indicated the pain medication to be "effective." On 11/23/13 at 1:35 a.m., the resident received APAP 500 mg tablet 1 po for right foot pain with no response documented.</p> <p>A MAR, dated 12/1/13 - 12/31/13 and reviewed on 1/22/14 at 1:45 p.m., indicated Resident #141 received Lortab 5/500 tablet 1/2 at 9:00 a.m., for general discomfort. The follow-up indicated the medication was "helpful." On 12/29/13 at 11:50 p.m., the resident received Lortab 5/500 po for generalized discomfort which was "helpful."</p> <p>A MAR for Resident #141, dated 1/1/14 - 1/13/14 and reviewed on 1/22/14 at 1:45 p.m., indicated the resident received APAP 500 mg tablet 1 po on 1/16/14 at 5:50 a.m. for "pain" and was "effective."</p> <p>2. An observation on 1/21/14 at 9:35 a.m., indicated Resident 123 was assisted into bed by the CNA. Resident #123 indicated she was not having any pain at that time but does have generalized pain.</p>						

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	<p>Resident #123's record was reviewed on 1/21/14 at 10:13 a.m. Resident #123 had diagnoses including, but not limited to, colon cancer and prostate cancer.</p> <p>The MDS (Minimum Data Set) assessment, dated 12/21/13, indicated Resident #123 did not have any mental impairment.</p> <p>Resident #123 had a physician's order dated 10/15/13, for Tylenol 325 mg (milligram) tablets 2 (two) every 4 hours prn (as needed) for pain.</p> <p>Resident #123 had a physician's order dated 11/8/13, for Norco 7/5/325 mg tablet 1 po every 4 hours prn for pain.</p> <p>A MAR (Medication Administration Record), dated 10/1/13 - 10/31/13, indicated Resident #123 received Tylenol on 10/15/13 at 12:00 p.m. for a headache which was "helpful."</p> <p>On 10/18/13 at 12:30 p.m., Resident #123 received Tylenol 325 mg tablets 2 po for abdominal pain which was "helpful."</p> <p>On 10/24/13 at 4:00 p.m., Resident #123 received Tylenol 650 mg po for</p>				

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	<p>pain which was "helpful."</p> <p>On 10/30/13 at 8:20 p.m., Resident #123 received Tylenol 650 mg po for pain which was "helpful."</p> <p>On 1/1/14 at 10:30 a.m., Resident #123 received Tylenol 325 mg tablet 2 po for a headache. The follow-up indicated the resident to have "some relief."</p> <p>On 1/12/14 at 11:15 a.m., Resident #123 received APAP 650 mg po for generalized pain which was "effective."</p> <p>On 1/16/14 at 11:30 a.m., Resident #123 received APAP Tylenol) 650 mg po for a headache which was "effective."</p> <p>On 1/17/14 at 2:00 p.m., Resident #123 received APAP 650 mg for a headache which was "effective."</p> <p>On 1/20/14 at 5:30 p.m., Resident #123 received Norco (a pain medication) 7.5/325 tablet 1 po for pain which was "helpful."</p> <p>On 1/21/14 at 3:15 a.m., Resident #123 received Norco 7.5/325 tab 1 po for pain which was "helpful."</p>						

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	<p>On 1/21/14 at 12:10 p.m., Resident #123 received Tylenol 650 mg po for general discomfort which was "helpful."</p> <p>During an interview on 1/22/14 at 3:50 p.m., LPN #4 indicated "PRN" medications are to be assessed using the "faces" and numeric pain scales prior to giving the medication and then afterward to reassess the resident's pain.</p> <p>During an interview on 1/22/14 at 4:04 p.m., LPN #1 indicated the staff is to use the "Baker" pain scale for assessing pain for the residents.</p> <p>A policy titled, "Pain Management," obtained from the DoN (Director of Nursing) on 1/22/14 at 5: 01 p.m., indicated the resident's pain will be assessed using he "Wong-Baker Faces Pain Rating Scale.</p> <p>3.1-48(a)(3)</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions, in that , the kitchen had a foul odor, soiled floors and soiled food prep areas, for example. This had the potential to affect 148 of 148 residents in the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the initial tour of kitchen, with the Dietary Manager present on 1/14/14 at 8:52 a.m., again on 1/15/14 at 9:02 a.m., and again on 1/21/14 at 9:00 a.m., the following issues were observed: <ul style="list-style-type: none"> a. A foul smell when entering the kitchen. b. Dirty, sticky floors in the kitchen area. c. In the dry storage area, the floors were sticky and dirty. 	F000371	<p>F0371 FOODPROCEDURE, STORE/PREPARE/SERVE-SANITARY Immediate Action – After receiving notification from ISDH the Dietary Manager reviewed each concern noted by surveyor, kitchen received a thorough cleaning. The Dietary Staff cleaned the floors in kitchen, dry storage area. There was no freezer bag of breaded chicken patties found but all items in freezer were checked to ensure dates were present, all bags were dated appropriately. Lights above the stove was cleaned, front of dishwasher were cleaned, drink prep area was cleaned, hand sanitizers were checked and filled, and all sinks were thoroughly cleaned. Any ice buildup in freezer was removed. The glass buffet serving cart was cleaned, the glass front of the refrigerator was cleaned and floor was also cleaned. All hand washing sinks were checked and filled. Review of Residents – No residents were affected. Corrective Action – Dietary Jobs/Assignments have been</p>	02/22/2014	

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	<p>d. In the freezer, a bag of breaded chicken patties open but not dated.</p> <p>e. The lights above the stove were dirty.</p> <p>f. On the front of the dishwasher an accumulation of dried-on food was observed.</p> <p>g. Crumbs were noted in the drink prep area.</p> <p>h. No hand sanitizer was available in two of three dispensers by the handwashing sink to right as you entered the kitchen.</p> <p>i. The sink on the right upon entering the kitchen was dirty with a build-up of calcium/lime deposits, dirt, and hair.</p> <p>j. An ice build-up was present in the freezer over boxes of food.</p> <p>2. The following observations were present on 1/21/14 at 9:30 a.m.:</p> <p>a. There was grease on the glass buffet serving cart and crumbs on the holding carts.</p> <p>b. The glass front of the refrigerator was greasy and splattered with food stains, and the floor was dirty.</p> <p>3. On 1/15/14 at 9:40 a.m., during an interview with dietary assistant #1, she indicated staff used the sink to the right to wash their hands. There was no soap in either</p>		<p>reviewed and updated. The staff member completing the Job will initial and the Supervisor will ensure the task is completed and will initial. Dietary staff will be in serviced on new Job/Assignments. Hand washing P&P reviewed, staff will receive in servicing on hand washing P&P. Monitoring– This revised process will be monitored daily by the Dietary Manager/Designee. The Dietary Manager/Designee will monitor the kitchen on a daily basis for cleanliness, and will do a weekly sanitation checklist of the entire kitchen. This process will be on going. New employees will receive instruction on hand washing P&P during orientation. Annually employees will receive in servicing of hand washing P&P. Random checks of hand washing techniques will be performed monthly by Staff Development/Designee for a minimum of 12 months.</p>		

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	<p>dispenser.</p> <p>4. During an interview on 1/21/14 at 9:40 a.m., Dietary Manager #3 indicated the sink to the right was used by staff for handwashing. When informed there was no soap in either of the dispensers, she notified housekeeping to have the dispensers refilled at that time.</p> <p>5. On 1/23/14 at 11:39 a.m., the sanitation of kitchen rules, cleaning schedules for kitchen and jobs, cleaning of kitchen documents were received. A document titled "Sanitation in Kitchen, dated 8/8/13," indicated the following: "1. Cleaning and sanitation schedules are posted 2. Each position has assigned tasks with frequency of cleaning 3. Procedures for cleaning equipment are written 4. Staff is to initial completion of cleaning assignments 5. MSDS sheets are available for all chemicals used by the food service staff."</p> <p>6. During a dining room observation in the Pavilion dining area on 1/14/14 at 11:35 a.m., the following observations were made:</p>				

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	<p>a. No drinks [beverages] were served and/or sitting at the tables where residents were eating.</p> <p>b. After serving dinner plates, CNA #2 was observed to have washed her hands for less than 8 seconds. That was observed on three separate occasions during that meal.</p> <p>c. LPN #3 served two plates and washed her hands for less than five seconds on each occasion.</p> <p>7. On 1/15/14 at 9:02 a.m., the following observations were made:</p> <p>a. There was no soap in two of three dispensers, third dispenser was lotion.</p> <p>b. Dietary Aide #1 was preparing fruit in cups with no gloves on.</p> <p>c. Dietary aide #2 was making trays for carts, picked up box of butter packets and poured into a bag, changed gloves and did not wash hands.</p> <p>8. A policy titled, "Hand Hygiene" was obtained on 1/23/14 at 11:39. The policy indicated hands were to be washed for (20) twenty seconds.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000372 SS=F	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.</p> <p>Based on observation and interview, the facility failed to dispose of garbage and refuse properly, in that, the trash cans were observed overflowing.</p> <p>Findings include: On 1/14/14 at 8:52 a.m. during the</p>	F000372	F0372 DISPOSEGARBAGE & REFUSE PROPERLY Immediate Action –All trash cans were immediately emptied upon notification by the ISDH. Review of Residents – No residents were affected. Corrective Action –The Dietary Managers and supervisors will monitor daily the trash cans to make sure staff is disposing of trash when full, and all foodservice staff to be aware to empty trash when lid does not	02/22/2014	

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	<p>initial kitchen tour, the following observations were identified:</p> <ol style="list-style-type: none"> 1. Throughout the general kitchen area a foul odor was noted. 2. Garbage cans with lids all overflowed with refuse on floor around cans. <p>On 1/21/14 at 9:30 a.m., garbage cans with lids were overflowed with refuse on floor. The odor in the kitchen again was noted.</p> <p>On 1/17/14 at 12:17 p.m.. garbage cans were full of trash and overflowed with refuse on floor.</p> <p>On 1/22/14 at 3:00 p.m., the evening shift dietary manager was interviewed about how often the trash taken out. She indicated it was everyone's job to empty trash as needed. She also indicated that was going to be her next job.</p> <p>3.1-21(i)(5)</p>		<p>fit securely. A Sanitation Checklist was created to monitor proper sanitation and cleanliness. Monitoring- The Sanitation Checklist will be utilized weekly by Dietary Manager/Designee to ensure Dietary Staff is compliant with their Job Descriptions/Assignments. This process will be followed a minimum of 12 months.</p>		

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F000465 SS=D	<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 interview the facility failed to ensure a safe, functional, sanitary, and comfortable environment for 3 of 40 rooms reviewed. (Room #114, #115, #91).</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 1/14/14 at 11:10 a.m., observed Room #114's bathroom doorway with no trim at the base and debris visible. The room was observed again on 1/16/14 at 1:48 p.m., and remained unchanged. On 1/14/14 at 4:03 p.m., observed the caulking around the base of the commode in Room #115 bathroom to be brown. The bathroom was observed again on 1/16/14 at 10:29 a.m., and remained unchanged. On 1/15/14 at 9:40 a.m., observed Room #91 with crushed food on the floor, missing paint on the bathroom frame and door, and soiled cloth belt wrapped around the inside of the bathroom door handle. 	F000465	<p>F0465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT Immediate Action – Rooms #91 and #118 deficiencies were corrected. Room #114, the trim required to complete repair was ordered, all other concerns were corrected. Review of Residents – Utilizing the Review of Residents form an audit of resident's rooms was made to ensure each resident's room has a safe, functional and comfortable environment. Corrective Action – After completing the initial assessment the Maintenance Supervisor and Environmental Service Supervisor were notified of findings so any corrections, if necessary, could be made. FORMCMS-20050 RESIDENT INTERVIEW & RESIDENT OBSERVATION will be utilized at least quarterly to assess resident's room. Monitoring– The UD/Designee will assess each resident's room at least quarterly, completing the Resident Room under Resident Observation portion of the CMS20050. This process will coincide with the MDS. Any concerns will be reviewed with Maintenance Supervisor and Environmental Service</p>	02/22/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155104	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2014
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	<p>The room was again observed on 1/16/14 at 10:45 a.m., and remained unchanged.</p> <p>4. On 1/16/14 at 2:45 p.m., the "Thorough Clean Check Off" provided by the ESS (Environmental Services Supervisor) was reviewed. The check off indicated floors and commodes were included in thorough cleaning list. The form indicated the thorough cleaning was to be completed monthly.</p> <p>On 1/16/14 at 2:45 p.m., the ESS was interviewed. The ESS indicated the deep cleaning of rooms are rotated every month. The ESS further indicated quarterly assessments are done of how well the rooms are deep cleaned.</p> <p>3.1-19(f)</p>		Supervisor. This process will be on going.		