

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2014
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NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 8, 9, 10, 11, and 12, 2014</p> <p>Facility number: 000509 Provider number: 155412 AIM number: 1002666620</p> <p>Survey team: Marcy Smith, RN-TC Dottie Plummer, RN Sherry Nagel-Smith, RN Patti Allen, SW</p> <p>Census bed type: SNF: 6 SNF/NF: 85 Total: 91</p> <p>Census Payor Type: Medicare: 3 Medicaid: 82 Other: 6 Total: 91</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December</p>	F000000		
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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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F000225 SS=D	<p>23, 2014; by Kimberly Perigo, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>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 interview and record review, the facility failed to immediately report to the State survey and certification agency and thoroughly investigate an allegation of mistreatment as indicated by facility policy for 1 of 3 residents reviewed for alleged violations. (Resident #130)</p> <p>Findings include:</p> <p>During resident interview on 12/8/2014 at 3:53 p.m., Resident #130 responded, "I was physically abused last weekend" when asked if staff, resident or anyone else here abused you verbally, physically or sexually. When questioned, resident indicated she told Physical Therapist (PT) during her weekend treatment she could not do anything with her left leg, but he went ahead and started exercises. The therapist was told to stop exercises because it hurt, but he did not stop exercising my leg. It hurt so bad I started crying and when I started crying, the therapist stopped. The therapist would not listen.</p> <p>In an interview on 12/8/2014 at 5:20 p.m., the Administrator indicated he</p>	F000225	<p>The plan of correction is to serve as Greenwood Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. F 225 483.13(c)(1)(ii)-(iii), (c)(2) – (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS I. The corrective actions to be accomplished for those residents found to have been affected by the practice. The allegation voiced by Resident #130 was immediately reported to the State survey and certification agency when the resident notified the state surveyor of her allegation of abuse and resident #130 was not harmed. II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Greenwood Health and Living Community have the potential to</p>	01/10/2015

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	<p>became aware of an allegation on 12/1/2014, when Resident #130 reported a physical therapy care issue to staff. The Social Service Director (SSD) interviewed the resident on 12/1/2014, relative to the complaint/allegation. The Administrator reported the resident's statement to the SSD was the resident denied the therapist intentionally wanted to harm her and denied the therapist abused her in any way. The Administrator felt the incident was not abuse and did not report the incident to Indiana State Department of Health or do any further investigation.</p> <p>Social Service Director notes dated 12/1/2014, regarding the incident were reviewed on 12/8/2014 at 5:30 p.m. The notes indicated the resident told SSD the therapist brought her down to the therapy gym in early morning of 11/29/2014. Resident #130 indicated her left knee had been hurting bad that morning and leg pain had been excruciating, but the therapist had been insistent in treating her. The resident indicated to SSD she had requested PT to stop shortly after the session started. PT had stopped the session and started encouraging her to do more, stating "No, lets do more." Social Service Director notes indicated resident agreed to resume exercises with her leg, but started to cry. The resident told her,</p>		<p>be affected by the alleged practice. Resident's with a BIMS of 8 or greater will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State, and CarDon policy and procedures. Resident family members/responsible parties will be interviewed for non-interviewable residents using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State, and CarDon policy and procedures. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The Administrator and Director of Nursing will be re-educated by the CarDon Clinical Nurse Specialist on the Abuse reporting policy and procedure and CQI abuse investigation checklist A CQI abuse investigation checklist is currently utilized by the Administrator and Director of Nursing for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees, and reporting employees to the ISDH and licensure boards of Indiana. QIS interview tool will be utilized to interview residents within the facility and family members to</p>		

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	<p>"He didn't listen, He didn't take my feelings into consideration." The resident indicated to the SSD the therapist encouraged her to work on another task not involving her legs, but the resident declined to resume therapy due to being in too much pain. The resident denied the therapist intentionally wanting to harm her or abusing her in any way. In the notes, the resident acknowledged the therapist tried to encourage her to participate in therapies. The resident was in a calm and appropriate mood and was not tearful during the interview. The SSD indicated during the interview the resident did not show any signs or symptoms of distress or mental anguish.</p> <p>In Interview on 12/8/2014 at 5:30 p.m., Resident #130 indicated therapy was provided in her room on 11/29/2014. PT continued to exercise her left leg even after she told him to stop, because movement caused her too much pain. PT told her "no, just once more." Resident indicated PT was holding her leg under her thigh with one hand and the other hand was on her foot. Resident indicated she thought abuse was too harsh a word and that incident was more "mistreatment and lack of consideration and respect for her feelings."</p> <p>The clinical record of Resident #130 was</p>		<p>ensure no further risks of harm exists in the current care environment for those residents potentially affected. In-service staff on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post-test was utilized to ensure the staff comprehended the abuse guidelines and policy/procedure to protect the residents from harm. Social Services will assess the resident to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Director of Nursing or designee for 30 days and at the end of the 30 days the frequency will be continued until compliance is 100% and then performed monthly by the Clinical Specialist or designee monthly tototal of 12 months. The Director of Nursing or designee will conduct weekly abuse QA audits by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the Director of Clinical Services to</p>				

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	<p>reviewed on 12/09/2014 at 9:13 a.m. Admission Minimum Data Set (MDS) assessment dated 11/24/2014, indicated the resident had a Brief Interview for Mental Status score of 15 (Cognitively Intact) and diagnoses which included, but not limited to, coronary artery disease, diabetes mellitus, hypertension, neuropathy, muscle weakness and chronic pain.</p> <p>On 12/8/2014 at 12:10 p.m., the Administrator provided the policy and procedure on "Abuse Prevention," dated 8/21/2013, and indicated the policy was the one currently being used by the facility. Policy and procedure included directives that all reports of resident abuse, neglect and injuries of unknown source shall be immediately and thoroughly investigated by facility management and when an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident when applicable. Policy indicated facility should notify the state licensing/certification agency responsible for surveying/licensing the facility immediately.</p> <p>3.1-28(d)</p>		<p>determine the ongoing frequency into the next 90 days to ensure staff are complying, understand and can identify abuse situations. The staff interviews will be conducted on all shifts to ensure staff are complying, understand, and can identify abuse situations</p> <p>The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 8 or higher monthly for a period of 12 months.</p> <p>The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with families of interviewable and non-interviewable residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 families monthly for a period of 12 months. The results of these reviews will be discussed at the monthly facility</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review the facility failed to ensure implementation of their abuse prevention policy in regard to immediately reporting to the State survey and certification agency and investigating an allegation of mistreatment for 1 of 3 residents reviewed for alleged violations. (Resident #130)</p> <p>Findings include:</p> <p>During resident interview on 12/8/2014 at 3:53 p.m., Resident #130 responded, "I was physically abused last weekend"</p>	F000226	<p>Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of Compliance 01/10/2015 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p> <p>F226 483.13 (c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES I. The corrective actions to be accomplished for those residents found to have been affected by the practice. The allegation voiced by Resident #130 was immediately reported to the State survey and certification agency when the resident notified the state surveyor of her allegation of abuse and resident #130 was not harmed. II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Greenwood Health and Living</p>	01/10/2015	

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	<p>when asked if staff, resident or anyone else here abused you verbally, physically or sexually. When questioned, resident indicated she told Physical Therapist (PT) during her weekend treatment she could not do anything with her left leg, but he went ahead and started exercises. The therapist was told to stop exercises because it hurt, but he did not stop exercising my leg. It hurt so bad I started crying and when I started crying, the therapist stopped. The therapist would not listen.</p> <p>In an interview on 12/8/2014 at 5:20 p.m., the Administrator indicated he became aware of an allegation on 12/1/2014, when Resident #130 reported a physical therapy care issue to staff. The Social Service Director (SSD) interviewed the resident on 12/1/2014, relative to the complaint/allegation. The Administrator reported the resident's statement to the SSD was the resident denied the therapist intentionally wanted to harm her and denied the therapist abused her in any way. The Administrator felt the incident was not abuse and did not report the incident to Indiana State Department of Health or do any further investigation.</p> <p>Social Service Director notes dated 12/1/2014, regarding the incident were</p>		<p>Community have the potential to be affected by the alleged practice. Resident's with a BIMSoF 8 or greater will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State, and CarDon policy and procedures. Resident family members/responsible parties will be interviewed for non-interviewable residents using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State, and CarDon policy and procedures. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The Administrator and Director of Nursing will be re-educated by the CarDon Clinical Nurse Specialist on the abuse reporting policy and procedure and CQI abuse investigation checklist. QIS interview tool will be utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected. In-service staff and on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post-test</p>		

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	<p>reviewed on 12/8/2014 at 5:30 p.m. The notes indicated the resident told SSD the therapist brought her down to the therapy gym in early morning of 11/29/2014. Resident #130 indicated her left knee had been hurting bad that morning and leg pain had been excruciating, but the therapist had been insistent in treating her. The resident indicated to SSD she had requested PT to stop shortly after the session started. PT had stopped the session and started encouraging her to do more, stating "No, lets do more." Social Service Director notes indicated resident agreed to resume exercises with her leg, but started to cry. The resident told her, "He didn't listen, He didn't take my feelings into consideration." The resident indicated to the SSD the therapist encouraged her to work on another task not involving her legs, but the resident declined to resume therapy due to being in too much pain. The resident denied the therapist intentionally wanting to harm her or abusing her in any way. In the notes, the resident acknowledged the therapist tried to encourage her to participate in therapies. The resident was in a calm and appropriate mood and was not tearful during the interview. The SSD indicated during the interview the resident did not show any signs or symptoms of distress or mental anguish.</p>		<p>was utilized to ensure the staff and contracted services comprehended the abuse guidelines and policy/procedure to protect the residents from harm. Social Services will assess the resident to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Director of Nursing for 30 days and at the end of the 30 days the frequency will be continued until compliance is 100% and then performed monthly by the Director of Nursing or designee for a total of 12 months. The Director of Nursing or designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the Director of Clinical Services to determine the ongoing frequency into the next 90 days to ensure staff are complying, understand and can identify abuse situations. The staff interviews will be conducted on all shifts to ensure staff are complying, understand, and can identify abuse situations The Administrator or designee will</p>				

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	<p>In Interview on 12/8/2014 at 5:30 p.m., Resident #130 indicated therapy was provided in her room on 11/29/2014. PT continued to exercise her left leg even after she told him to stop, because movement caused her too much pain. PT told her "no, just once more." Resident indicated PT was holding her leg under her thigh with one hand and the other hand was on her foot. Resident indicated she thought abuse was too harsh a word and that incident was more "mistreatment and lack of consideration and respect for her feelings."</p> <p>The clinical record of Resident #130 was reviewed on 12/09/2014 at 9:13 a.m. Admission Minimum Data Set (MDS) assessment dated 11/24/2014, indicated the resident had a Brief Interview for Mental Status score of 15 (Cognitively Intact) and diagnoses which included, but not limited to, coronary artery disease, diabetes mellitus, hypertension, neuropathy, muscle weakness and chronic pain.</p> <p>On 12/8/2014 at 12:10 p.m., the Administrator provided the policy and procedure on "Abuse Prevention," dated 8/21/2013, and indicated the policy was the one currently being used by the facility. Policy and procedure included directives that all reports of resident</p>		<p>audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 8 or higher monthly for a period of 12 months The QIS abuse questionnaire will be integrated into the facility routine customerservice/care program and utilized monthly with families of interviewable and non-interviewable residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 families monthly for a period of 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of Compliance 01/10/2015</p>		

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F000279 SS=D	<p>abuse, neglect and injuries of unknown source shall be immediately and thoroughly investigated by facility management and when an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident when applicable. Policy indicated facility should notify the state licensing/certification agency responsible for surveying/licensing the facility immediately.</p> <p>3.1-28(a)</p> <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</p>		The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	<p>§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 ensure a care plan was developed for a resident with a gastrostomy tube, (Resident #123) and a care plan for pain management of the resident's pain as identified in a comprehensive assessment. (Resident #130)</p> <p>Findings include:</p> <p>1. In interview on 12/8/2014 at 3:57 p.m., Resident #130 indicated she had constant pain in the left knee. Nothing seems to relieve the pain except pain medication and pain caused her difficulty in sleeping.</p> <p>The clinical record of Resident #130 was reviewed 12/09/2014 at 9:13 a.m. The Admission Minimum Data Set (MDS) assessment dated 11/24/2014, indicated a Brief Interview for Mental Status score of 15 (Cognitively Intact) and diagnoses which included, but not limited to, diabetes mellitus, neuropathy and chronic pain.</p> <p>A Pain assessment dated 11/17/2014, indicated resident's pain was constant and</p>	F000279	<p>F 279 483.20(d), 483.20(k)</p> <p>(1)Develop Comprehensive Care Plans I.The corrective actions to be accomplished for those residents found to have been affected by the practice</p> <p>Resident# 130 has a care plan that accurately reflects the resident's pain and effects of pain on the resident's sleep, activities of daily living, and day to day activities, as well as approaches for each limitation. Resident#123 has a care plan for a gastric tube through which the resident receives nutrition and hydration.</p> <p>II.The facility will identify other residents that may potentially be affected by the practice</p> <p>Other residents who experience pain, as indicated on the MDS assessment, will be reviewed for accuracy of care plans and implementation of interventions to address any limitations that result from pain. Care plans for any resident found to be affected will be updated accordingly. Other residents with a gastric tube have been identified and will be reviewed for care plans addressing the gastric tube. Care plans for any resident found to be affected will be updated accordingly.</p> <p>III.The facility will put into place the following systematic changes to ensure that the practice does not</p>	01/10/2015			

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	<p>persistent with onset at all times of the day; from early morning to night. The pain made it hard to sleep at night and limited daily activities. Measures to relieve pain were rest and analgesics.</p> <p>A "General Order," dated 11/18/2014, on the physician orders indicated "Assess resident's pain rating every shift. Resident voices manageable pain rating of 4 out of 10 [Pain described at severity of Levels between 1-10, with 10 being the highest level of pain]."</p> <p>Care Area Assessment Pain Worksheet dated 11/26/2014, indicated, "Pain effect on function" indicated pain disturbed sleep, limited independence with at least some activities of daily living and limits day-to-day activities.</p> <p>A care plan with a start date of 11/18/2014, indicated problem "Resident has potential for chronic pain R/T diagnosis." The problem did not identify resident had constant and persistent pain which disturbed sleep, limited activities of daily living and limited day-to-day activities as per assessment.</p> <p>Goal on care plan was, "Resident will verbalize effective management AEB [as evidenced by] pain level of 8 or below per Resident stated tolerance." Goal did</p>		<p>recur. The systemic change includes:</p> <ul style="list-style-type: none"> ·Licensed nurses assigned to complete MDS assessments will be educated regarding implementation of care plans that accurately reflect the pain a resident experiences as well as limitations that result from the resident's pain and interventions to address each limitation resulting from the resident's pain. ·Licensed nurses assigned to implement and/or update gastric tube care plans will be educated regarding implementation of care plans upon admission or gastric tube placement. <p>IV.The facility will monitor the corrective action by implementing the following measures. The Director of Nursing, or designee, will complete a QA tool to audit the implementation of care plans that accurately reflect a resident's pain as indicated on the MDS assessment upon completion of each MDS assessment for 30 days, then upon completion of 10 random MDS assessments a month for 90 days, then upon completion of five random MDS assessments a month for a total of twelve months of monitoring.</p> <p>The Director of Nursing, or designee, will complete a QA tool to audit the implementation of care plans for gastric tubes upon admission and weekly for 60 days, then monthly for 90 days, then quarterly for a total of 12</p>		

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	<p>not reflect assessment that "Resident voices manageable pain rating of 4 out of 10."</p> <p>Interventions on care plan included administering pain medication and assess effectiveness, monitoring and recording complaints of pain, observing for and recording any non-verbal signs of pain. Interventions did not address approaches for disturbed sleep, limited independence with at least some activities of daily living and limits day-to-day activities as they relate to pain.</p> <p>2. The clinical record of Resident #123 was reviewed on 12/11/14 at 10:15 a.m. Diagnoses for the resident included, but were not limited to, feeding problem and dysphagia (difficulty swallowing).</p> <p>Resident #123 was admitted to the facility on 7/14/14. An admission Minimum Data Set assessment, dated 7/21/14, indicated the resident had a feeding tube (a tube surgically placed in the stomach through which nutritional feedings, medications, and water can be administered) and received nutrition and hydration through the tube.</p> <p>A care plan for the feeding tube was not found in the resident's record. On 12/11/14 at 3:09 p.m., the Director of</p>		<p>months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of Compliance 01/10/2015 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p>				

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F000280 SS=B	<p>Nursing indicated the facility had not created a care plan for Resident #123's feeding tube.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</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 interview and record review, the facility failed to revise the comprehensive care plan for a resident who was no longer receiving anticoagulant (a medication used to prevent blood clots) therapy for 1 of 5 residents reviewed for unnecessary medication use. (Resident #39)</p> <p>Findings include:</p>	F000280	<p>F 280 483.20(d)(3), 483.10(k) (2)Right to Participate Planning Care-Revise CP I.The corrective actions to be accomplished for those residents found to have been affected by the practice The anticoagulant care plan for resident #39 has been discontinued. II.The facility will identify other residents that may potentially be affected</p>	01/10/2015

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	<p>The clinical record of Resident #39, completed on 12/10/14 at 9:32 a.m., indicated the resident had diagnoses including, but not limited to diabetes.</p> <p>A review of the written plans of care indicated the resident had a current plan of care dated 4/18/13, for having the need for monitoring related to anticoagulant therapy. Interventions included administering anticoagulants and performing laboratory (lab) testing as ordered.</p> <p>A recapitulation of physician's orders for the month of December 2014, lacked current orders for anticoagulant medication and lab monitoring for anticoagulant therapy.</p> <p>During an interview with Unit Manager #3 on 12/10/14 at 4:30 p.m., the UM #3 indicated the resident was not currently receiving an anticoagulant medication. UM #3 indicated the resident had received Coumadin, an anticoagulant, beginning 4/18/13, for preventative treatment following a broken femur (thigh bone). On 5/15/13, the Coumadin was discontinued and Xarelto, a different anticoagulant was started. The Xarelto was discontinued on 8/1/13. The UM indicated the care plan was not updated</p>		<p>bythe practice Other residents with a care plan for anticoagulant medications have been identified and will be reviewed for accuracy of care plans and interventions. Any care plans found to be inaccurate will be corrected immediately. III.The facility will put into place the following systematic changes to ensure that the practice does not recur. The systemic change includes:</p> <ul style="list-style-type: none"> -Licensed nurses assigned to implement and/or update anticoagulant care plans will be educated regarding updating of care plans with any medication changes ordered by the physician. <p>IV.The facility will monitor the corrective action by implementing the following measures. The Director of Nursing, or designee, will complete a QA tool to audit the accuracy of anticoagulant care plans that weekly for 30 days, then bi-weekly for 60 days, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of</p>		

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F000282 SS=E	<p>when the anticoagulant was discontinued.</p> <p>During an interview with the Director of Nursing (DON) at 4:30 p.m. on 12/10/14, the DON indicated the care plan should have been updated when the anticoagulant medication was discontinued.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide services according to written plans of care for a resident receiving sliding scale insulin (Resident #61), failed to notify the physician of blood glucose results (Resident #61), failed to perform laboratory testing as ordered by the physician (Resident #39), and failed to provide assistance with oral care and Activities of Daily Living (ADL's) for 2 of 3 residents reviewed for ADL care (Resident #85, Resident #139).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #61</p>	F000282	<p>Compliance 01/10/2015 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p> <p>F 282 483.20(k)(3)(ii) Services by Qualified Persons/Per Care Plan I. The corrective actions to be accomplished for those residents found to have been affected by the practice Resident#61 is receiving insulin per physician order. The lab draw was completed for resident #39 per physician order and the results were within normal limits. Lab tests are being completed per physician order for resident #39. Resident#85 is receiving showers and oral care per preference. Resident#139 received showers and oral care per preference. II. The facility will identify other residents that may potentially be affected</p>	01/10/2015			

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	<p>was reviewed on 12/10/14 at 8:34 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus (a disease in which the body is unable to control the amount of sugar in the blood because it does not have enough insulin).</p> <p>A care plan for Resident #61, dated 11/4/14, indicated she had potential for high and low blood sugars related to diabetes. Interventions included, "Administer accuchecks [a fingerstick blood test to measure blood sugar] per MD [medical doctor] order, and provide [sliding scale insulin]...per MD order."</p> <p>A physician's order, dated 11/17/14, indicated Resident #61 was to receive Novolog insulin 4 times per day, depending on the results of her fingerstick blood test, according to the following sliding scale:</p> <p>Blood sugar (BS) less than 60: call MD. BS 0 - 174, give 0 units. BS 175 - 199, give 3 units BS 200 - 224, give 4 units BS 225 - 249, give 5 units BS 250 - 274, give 6 units BS 275 - 325, give 8 units BS greater than 325, Call MD.</p> <p>A review of a Diabetic Administration History, dated 11/17/14 - 12/10/14,</p>		<p>by the practice Other residents receiving insulin have been identified and are being reviewed for administration of insulin per physician order. Other residents with recurring lab orders have been identified and are being reviewed for completion. Other residents requiring assistance with bathing and/or hygiene needs have been identified and are being reviewed for completion of bathing and oral hygiene per the plan of care.</p> <p>III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The systemic change includes:</p> <ul style="list-style-type: none"> · Licensed nurses will be educated regarding administration of insulin per physician order as well as procedure for sliding scale insulin administration. · Unit Managers will be educated regarding monitoring of completion of lab tests. · Certified nurse aides will be educated regarding completion of bathing and oral hygiene per the resident's plan of care and accurate documentation of care provided in the resident's chart. · Licensed nurses are being educated regarding overseeing the completion of bathing and oral hygiene per resident's plan of care. · Admission care packages with personal care items and list of contents are being provided to 		

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	<p>indicated the following:</p> <p>11/18/14 at 4:00 p.m.: BS = 428. No documentation the physician was notified nor any sliding scale insulin was given.</p> <p>11/18/14 at 8:00 p.m.: BS = 428. No documentation any sliding scale insulin was given.</p> <p>11/19/14 at 12:00 p.m.: BS = 511. No documentation the physician was notified nor any sliding scale insulin given.</p> <p>11/26/14 at 12:00 p.m.: BS = 330. No documentation the physician was notified nor any sliding scale insulin given.</p> <p>11/27/14 at 8:00 a.m.: BS = 358. No documentation any sliding scale insulin was given.</p> <p>12/1/14 at 8:00 a.m.: BS = 453. No documentation any sliding scale insulin was given.</p> <p>12/6/14 at 8:00 a.m.: BS = 466. No documentation any sliding scale insulin was given.</p> <p>12/7/14 at 8:00 a.m.: BS = 438. No documentation any sliding scale insulin was given.</p>		<p>residents upon admission.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures. The Director of Nursing, or designee, will complete a QA tool to audit the completion of recurring lab tests daily (including weekends) for 30 days, then weekly for 60 days, then monthly for a total of 12 months of monitoring. The Director of Nursing, or designee, will complete a QA tool to audit the administration of insulin as ordered by the physician (including weekends) for 30 days, then three times weekly for 60 days, then weekly for a total of 12 months of monitoring. The Director of Nursing, or designee, will complete a QA tool to audit the completion of bathing and oral hygiene for residents requiring assistance daily (including weekends) for 30 days, then 3 days weekly for 60 days, then weekly for a total of 12 months of monitoring. The Director of Nursing, or designee, will interview 40 residents weekly regarding completion of bathing and oral hygiene for 30 days, then 20 residents weekly for 60 days, then 10 residents weekly for a total of 12 months of monitoring. The Unit Manager, or designee, will audit 5 residents daily for clean appearance and oral cavity for 30 days, 10 residents weekly for 60 days, and 20 residents monthly for a total of 12 months</p>		

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	<p>12/9/14 at 8:00 a.m.: BS = 347 No documentation the physician was notified nor any sliding scale insulin was given.</p> <p>On 12/10/14 at 2:25 p.m., the Director of Nursing indicated, when the fingerstick blood test results are over the sliding scale parameters, in this case, 325, the computer system automatically enters a zero (0) for units of sliding scale insulin given. This zero (0) cannot be changed. She indicated, what the nurses should have done was document when the physician was notified and written a one time order for the amount of sliding scale insulin that was supposed to be given. Then documented in the progress notes the insulin was given per physician order.</p> <p>2. Clinical record review of Resident #39 completed on 12/10/14 at 9:32 a.m., indicated the resident had diagnoses including, but not limited to, diabetes.</p> <p>A review of the recapitulation of physician's orders for December 2014, indicated the resident had an order dated 4/14/14, to have a hemoglobin A1C (a laboratory [lab] test performed to check an average blood glucose for the past 2-3 months) completed on 4/14/14 and then every 6 months.</p> <p>No hemoglobin A1C results were in the</p>		<p>of monitoring. The nursing managers will audit each resident room weekly for oral hygiene supplies for 30 days, then bi-weekly for 60 days, then monthly for a total 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of Compliance 01/10/2015 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p>				

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	<p>clinical record.</p> <p>During an interview with the Director of Nursing (DON) on 12/10/14 at 4:30 p.m., the DON indicated the hemoglobin A1C was not completed as ordered by the physician and no results were available. The DON indicated the lab had been contacted to obtain the results and the lab lacked a request for the test to be completed every 6 months.</p> <p>On 12/10/14 at 4:34 p.m., the DON provided lab results for a hemoglobin A1C completed 4/17/14, and indicated the lab was not completed in October 2014, as ordered.</p> <p>On 12/11/14 at 9:28 a.m., the DON provided a policy dated October 2010, titled Lab and Diagnostic Test Results and indicated the policy was the one currently used by the facility. The policy indicated, "...2. The staff will process test requisitions and arrange for tests...3. The laboratory...will report test results to the facility...."</p> <p>3. a. The clinical record of Resident #85 was reviewed on 12/10/14 at 3:00 p.m. Diagnoses for the resident included, but were not limited to, fractured lower leg, difficulty walking and muscle weakness.</p>						

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	<p>Resident #85 was admitted to the facility on 11/18/14. An admission Minimum Data Set assessment, dated 11/25/14, indicated Resident #85 was independent in her ability to make decisions and she was totally dependent on staff for bathing and hygiene needs.</p> <p>a.1. On 12/19/14 at 2:18 p.m., Resident #85 also indicated she had not received a shower since her admission to the facility. She indicated she had only had a bed bath, her hair hadn't been washed, and, "I just don't feel clean."</p> <p>Review of an Activities of Daily Living report, dated 11/18/14 through 12/14/14, indicated Resident #85 had received no showers, 3 bed baths, and partial bed baths during that time frame.</p> <p>On 12/10/14 at 3:05 p.m., the Director of Nursing indicated the staff probably hadn't given Resident #85 a shower because of the cast on her leg, but as long as the cast was covered with plastic, the resident could receive showers.</p> <p>a. 2. On 12/9/14 at 2:29 p.m., the resident indicated her teeth had only been brushed one time since she was admitted. She indicated her daughter helped her that time, and facility staff had never asked her if she wanted help brushing her</p>			

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	<p>teeth.</p> <p>No documentation was found in the resident's record which indicated she had receive oral care since her admission.</p> <p>A care plan for Resident #85, dated 11/18/14, indicated a problem of, "Activities of Daily Living...Resident/family have voiced preferences for resident care." Interventions included, "Offer to provide oral care AM/PM," and, "Offer to shower resident on preferred shower day [Monday/Thursday]...Offer to wash resident's hair per preference during shower..."</p> <p>4. The clinical record review of Resident #139 completed on 12/11/2014 at 5:17 p.m., indicated the resident had diagnoses including, but not limited to, enteritis (inflammation of the small intestine). Resident #139 was admitted to the facility on 12/4/14.</p> <p>On 12/8/14 at 3:30 p.m., the hair of Resident #139 was observed to have a greasy appearance and was laying in sections on top of the head.</p> <p>During a Stage 1 interview on 12/9/14 at 10:48 a.m., Resident #139 indicated no toiletries, including a tooth brush and</p>			

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NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142
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	<p>toothpaste, had been provided by the facility until requested by the resident on the evening of 12/8/14. The resident indicated, "My teeth were getting pretty nasty so I finally asked if someone could give me a tooth brush and tooth paste. I haven't had a bath since I have been here so I asked if I could have a shower too. They gave me one last night [12/8/14]." The resident indicated assistance was needed to complete Activities of Daily Living (ADL's) such as bathing and cleaning the lower body and the facility had not provided assistance since admission.</p> <p>On 12/10/14 at 3:25 p.m., the Director of Nursing (DON) provided a copy of the Point of Care Report for Resident #139. The report indicated the resident required extensive assistance of one staff person for bathing, personal hygiene, transfers, bed mobility, and toileting. The report lacked documentation of the completion of a complete bath or shower for the resident.</p> <p>During an interview with the DON on 12/10/14 at 4:00 p.m., the DON indicated the expectation was for a resident to have a partial bath completed 2 times a day and a shower 2 times a week from the time of admission. The DON indicated Resident #139 had a shower completed</p>			

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F000312 SS=D	<p>on 12/8/14, on the evening shift.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to provide assistance with activities of daily living (ADL's) which included bathing and oral care for 2 of 3 residents reviewed for ADL care. (Resident #139 and Resident #85)</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #139 completed on 12/11/2014 at 5:17 p.m., indicated the resident had diagnoses including, but not limited to, enteritis (inflammation of the small intestine). Resident #139 was admitted to the facility on 12/4/14.</p> <p>On 12/8/14 at 3:30 p.m., the hair of Resident #139 was observed to have a greasy appearance and was laying in sections on top of the head.</p>	F000312	<p>F 312 483.25(a)(3) ADL Care Provided For Dependent Residents I.The corrective actions to be accomplished for those residents found to have been affected by the practice Resident #85 is receiving showers and oral care per preference. Resident #139 received showers and oral care per preference. II. The facility will identify other residents that may potentially be affected by the practice Other residents requiring assistance with bathing and/or hygiene needs have been identified and are being reviewed for completion of bathing and oral hygiene per the plan of care. III.The facility will put into place the following systematic changes to ensure that the practice does not recur. The systemic change includes: ·Certified nurse aides will be educated regarding completion of bathing and oral hygiene per the</p>	01/10/2015			

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	<p>During a Stage 1 interview on 12/9/14 at 10:48 a.m., Resident #139 indicated no toiletries, including a tooth brush and toothpaste, had been provided by the facility until requested by the resident on the evening of 12/8/14, 4 days after admission to the facility. The resident indicated, "My teeth were getting pretty nasty so I finally asked if someone could give me a tooth brush and tooth paste. I haven't had a bath since I have been here so I asked if I could have a shower too. They gave me one last night [12/8/14]." The resident indicated assistance was needed to complete Activities of Daily Living (ADL's) such as bathing and cleaning the lower body and the facility had not provided assistance since admission.</p> <p>On 12/10/14 at 3:25 p.m., the Director of Nursing (DON) provided a copy of the Point of Care Report for Resident #139. The report indicated the resident required extensive assistance of one staff person for bathing, personal hygiene, transfers, bed mobility, and toileting. The report lacked documentation of the completion of a complete bath or shower for the resident.</p> <p>During an interview with the DON on</p>		<p>resident's plan of care and accurate documentation of care provided in the resident's chart.</p> <ul style="list-style-type: none"> ·Licensed nurses are being educated regarding overseeing the completion of bathing and oral hygiene per resident's plan of care. ·Admission care packages with personal care items and list of contents are being provided to residents upon admission. <p>IV. The facility will monitor the corrective action by implementing the following measures. The Director of Nursing, or designee, will complete a QA tool to audit the completion of bathing and oral hygiene for residents requiring assistance daily (including weekends) for 30 days, then 3 days weekly for 60 days, then weekly for a total of 12 months of monitoring. The Director of Nursing, or designee, will interview 40 residents weekly regarding completion of bathing and oral hygiene for 30 days, then 20 residents weekly for 60 days, then 10 residents weekly for a total of 12 months of monitoring. The Unit Manager, or designee, will audit 5 residents daily for clean appearance and oral cavity for 30 days, 10 residents weekly for 60 days, and 20 residents monthly for a total of 12 months of monitoring. The nursing managers will audit each resident room weekly for oral hygiene supplies for 30 days, then</p>		

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	<p>12/10/14 at 4:00 p.m., the DON indicated the expectation was for a resident to have a partial bath completed 2 times a day and a shower 2 times a week from the time of admission. The DON indicated Resident #139 had a shower completed on 12/8/14 on the evening shift.</p> <p>2. The clinical record of Resident #85 was reviewed on 12/10/14 at 3:00 p.m. Diagnoses for the resident included, but were not limited to, fractured lower leg, difficulty walking, and muscle weakness.</p> <p>Resident #85 was admitted to the facility on 11/18/14. On 12/9/14 at 2:29 p.m., the resident indicated her teeth had only been brushed one time since she was admitted. She indicated her daughter helped her that time and facility staff had never asked her if she wanted help brushing her teeth.</p> <p>An admission Minimum Data Set assessment, dated 11/25/14, indicated Resident #85 was independent in her ability to make decisions, and she was totally dependent on staff for bathing and hygiene needs.</p> <p>A care plan for Resident #85, dated 11/18/14, indicated a problem of, "Activities of Daily</p>		<p>bi-weekly for 60 days, then monthly for a total 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of Compliance 01/10/2015 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p>	

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F000431 SS=D	<p>Living...Resident/family have voiced preferences for resident care." Interventions included, "Offer to provide oral care AM/PM."</p> <p>3.1-38(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except</p>			

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	<p>when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe storage of medications relative to labeling of multi-dose vials and disposal of expired medications in 1 of 2 medication storage rooms, failed to safely secure stored medications in 1 of 4 medication carts and failed to safely handle refused medications for 3 of 16 residents on the 200 Hallway. (Residents 79, 108 and 130)</p> <p>Findings include:</p> <p>1. On 12/11/2014 at 8:48 a.m. three open vials of Tubersol (Tuberculosis Diagnostic Agent) were observed on the shelf in the door of the refrigerator in the medication room on 400-500 hallway. Two vials did not have a date as to when they were opened. One vial was labeled 9/30/2014. LPN #4 indicated she believed the date of 9/30/2014 referred to the date opened.</p> <p>In interview on 12/11/2014 at 8:49 a.m., LPN #4 indicated all vials should be dated when opened, but she was not sure of the time frame when vials should be discarded after opening.</p>	F000431	<p>F 431 483.60(b),(d),(e) Drug Records, Label/Store Drugs & Biologicals I.The corrective actions to be accomplished for those residents found to have been affected by the practice Other undated or expired opened vials of Tubersol were discarded per policy. No residents were affected. Resident #130, #108, and #79 did not receive the medications that were stored outside of their original packages. The medications were discarded per policy and no residents were affected. The medication cart was secured upon identification of concern. No residents were affected. II. The facility will identify other residents that may potentially be affected by the practice No residents were affected. III.The facility will put into place the following systematic changes to ensure that the practice does not recur. The systemic change includes:</p> <ul style="list-style-type: none"> ·Licensed nurses will be educated regarding medication storage to include medication cart, refrigerator and medication room. ·Licensed nurses will be educated regarding medication administration and policy addressing refusal of medications. 	01/10/2015			

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	<p>In interview on 12/11/2014 at 10:00 a.m. Director of Nursing (DON) indicated Tubersol vials should be dated when opened and discarded 28 days after opening, as per facility policy.</p> <p>On 12/9/14 at 2:10 p.m., the DON provided a policy titled, "Drug Storage," and indicated it was the policy currently used by the facility. The policy indicated, "... PPD (TB) vaccine...vials requiring refrigeration need to be dated when opened. All vials should be discarded within 28 days of the open date."</p> <p>Physician Desk Reference for pharmaceuticals indicated storage for Tubersol agent included "Discard vials entered and in use for 30 days."</p> <p>2. During medication pass 12/11/2014 at 8:09 a.m. 200 hallway, three individual medication cups with medications were observed stored together inside same compartment of the top drawer of the medication cart. Medications in each cup were not in their original packages. RN #3 indicated she had "poured" medications for three residents, but residents had refused the medications because they wanted to take them after breakfast. RN #3 indicated that after residents refused the medications, she labeled each individual cup with</p>		<p>·LPN#4 was educated regarding medication storage policy specifically related to the storage of Tubersol.</p> <p>·RN#3 was educated regarding the proper storage of medication.</p> <p>·LPN#4 was educated regarding medication storage policy.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures. The Unit Manager, or designee, will complete a QA tool to audit all refrigerators for opened vials of Tubersol and discard any undated or expired vials per policy weekly for 30 days, then bi-weekly for 60 days, then monthly for a total of 12 months of monitoring. The Unit Manager, or designee, will complete a QA tool to audit the storage of medications in the medication carts weekly for 30 days, then bi-weekly for 60 days, then monthly for a total of 12 months of monitoring. The Staff Development Coordinator, or designee, will complete a QA tool to audit one medication pass weekly for 30 days, then bi-weekly for 60 days, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of</p>	

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	<p>resident's name and placed them in the drawer to give after breakfast. RN #3 indicated she was not aware if storing medications in this manner was facility policy.</p> <p>In interview 12/11/2014 at 9:29 a.m. DON indicated medications should be discarded if resident refuses them and repoured when resident is ready to take medications.</p> <p>On 12/11 2014 at 10:00 a.m. medications were identified by DON and list presented to surveyor. Resident #130 had four medications poured, Resident #108 had ten medications poured and Resident #79 had five medications poured.</p> <p>On 12/11/2014 at 10:00 a.m., the DON provided an undated policy and procedure on "Medication Administration: General Policies & Procedures," and indicated the policy was the one currently being used by the facility. Policy and procedure indicated "If a dose of regularly scheduled medication is withheld, refused or spit out, the nurse or approved designee is to initial and circle the initials in the resident's MAR (Medication Administration Record) in the space provided for that dosage administration.</p>		<p>reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date. Date of Compliance 01/10/2015 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p>				

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F000465 SS=E	<p>An explanatory note is then to be entered on the reverse side of the record in the space provided for PRN (As needed) documentation."</p> <p>3. On 12/11/2014 from 11:41-11:46 a.m. the medication cart for 500 hallway was observed unlocked. The cart was situated at the side of the nurses' station with the drawers facing outward. A nurse was sitting at nurses' station. The medication cart drawers were not in visual field of the nurse. Three residents, identified by LPN #4 as being alert and oriented and mobile in their wheelchair, were noted near the medication cart. During the time frame a housekeeper and Certified Nursing Assistant walked past the drawers of the unlocked cart.</p> <p>3.1-25(m) 3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe environment was provided for residents in that the door to the mechanical room in the south dining room was unlocked.</p>	F000465	<p>F465 483.70 (h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT I.The corrective actions to be accomplished for those residents found to have been</p>	01/10/2015			

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	<p>Findings include:</p> <p>During an observation of the south dining room on 12/08/2014 at 12:36 p.m., the door to the mechanical room was unlocked. Inside the mechanical room, a housekeeping cart was located in front of a large electrical panel. The housekeeping cart was unlocked and contained cleaning supplies including, "Betco AF79 concentrate," a cleaning solution. Included on the label of the cleaning solution was a warning indicating the solution was hazardous to humans and animals.</p> <p>A sign on the electrical panel and on the wall next to the panel indicated, "Caution keep 36" [inches] clear for electrical panel." A yellow caution tape was affixed on the floor in front of the panel and created a 36" perimeter. The housekeeping cart and 14 cardboard boxes containing paper towels and toilet paper were located inside of the yellow caution tape perimeter.</p> <p>During an observation of the room with the Administrator at 12:59 p.m., the Administrator indicated the door to the room should be locked at all times when unattended and the housekeeping cart should not be located with in the 36"</p>		<p>affected by the practice. There was not a particular resident identified to have been affected by the alleged practice. The mechanical room door has been secured with an automatic lock that locks at all times. Housekeeping carts are not stored in the mechanical room and are not located near an electrical panel. Housekeeping carts that contain cleaning supplies are locked at all times. The floor tiles for the 100, 200, 400 and 500 medication rooms, the floor tiles for the soiled utility room on 400 – 500 hallway, and the floor tiles for the storage room across from the nurses station on 400 – 500 hallway have all been stripped and a new coat of wax has been applied. The affected rooms are not dull, dirty, discolored and no longer have gray and black markings. The ceramic tiles in the 400 hall shower room no longer have sharp edges exposed; they have been covered with a protective covering and/or replaced. The bolts anchoring toilets to the floor in the bathrooms of rooms 109, 111, 209, 211, 213 and 215 and in the shower room on 100 unit have all be covered with a protective covering. The hole in the inside base of the door to the bathroom in room 114 has been fixed and no longer exists. The floor tile in the bathrooms of room 209, 211, 213 and 215 have been fixed and no longer have irregular</p>		

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	<p>perimeter of the electrical panel. The Administrator moved the housekeeping cart beyond the yellow perimeter and indicated the cart should also be locked when unattended as the cleaning supplies stored in the cart were potentially hazardous to the residents. The Administrator locked the door and exited the room.</p> <p>On 12/8/14 at 1:05 p.m., Housekeeper #5 unlocked the mechanical room door and pushed a second cart into the mechanical room. Upon observation of the room, both of the housekeeping carts were located in front of the electrical panel well with in the yellow caution perimeter.</p> <p>During an interview with the Maintenance Director on 12/08/14 at 1:21 p.m., the Maintenance Director indicated the facility was limited on storage area and the housekeeping carts were stored in the mechanical room. The Maintenance Director indicated the carts should not have been stored with in the yellow caution tape perimeter and the door to the room should be locked at all times.</p> <p>3.1-19(f) 2. Based on observation and interview, the facility failed to provide maintenance and housekeeping services to keep</p>		<p>gouged shapes. II.The facility will identify other residents that may potentially be affected by the practice. Any and all other storage room doors have been examined and have locks to prevent from being left unlocked while unattended. Housekeeping carts are stored in a designated area, all housekeeping carts have locks on them, and all housekeeping carts are locked when left unattended. No other medication rooms exist other than the ones identified at the two nurses' stations. Other storage rooms have been assessed and none of the floors were found to be dull, dirty, discolored and are not gray with black markings. Other shower rooms have been examined by the Administrator and Maintenance Director to ensure no other sharp edges are exposed on the ceramic tiles. The other toilets in the facility and the anchor hardware have been assessed and covered to protect the staff, visitors and residents from any exposed bolts. All other bathroom doors have been examined and no other holes have been identified. The floor tile in other residents rooms have the potential to be damaged, the other floor tiles for other residents rooms have been assessed and corrective action/fixes have been made in each incident. III.The facility will put into place the following systematic changes to ensure that the practice</p>		

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	<p>resident bathrooms, medication rooms, utility rooms and storage areas clean and in good repair for 2 of 2 nursing units.</p> <p>Findings include:</p> <p>During initial tour 12/8/2014 at 10:15 a.m. and environmental tour 12/11/2014 at 2:53 p.m. with Administrator, Maintenance Supervisor and Housekeeping Supervisor the following was observed:</p> <p>a. Floor tile in medication rooms on 100-200 and 400-500 hallways, soiled utility room on 400-500 hallway, and storage room across from nurses' station on 400-500 hallway appeared dull and dirty, were discolored light gray and had numerous gray/black markings.</p> <p>b. Ceramic tiles were chipped in three areas of walls in resident shower room on 400 hallway exposing sharp edges.</p> <p>c. Bolts anchoring toilets to floor in adjoining bathrooms of rooms 109, 111, 209, 211, 213 and 215 and shower room on 100 unit were uncovered and of varying lengths. Bolts had exposed sharp threads and tops. Sealant around base of toilets was either missing or discolored black.</p>		<p>does not recur. Maintenance has been provided re-education about reporting the unsafe or unclean condition of environmental surfaces such as floors, ceramic tiles, walls, equipment, bolts, or other hardware securing equipment like toilets and baseboards directly to the Administrator for resources to make repairs immediately. Housekeeping employee #5 received re-education about proper storage of housekeeping supplies, carts and locking storage and electrical room doors when unattended. Housekeeping, maintenance and other staff have received re-education on reporting to the Administrator or direct supervisor any and all unsafe functional and potentially unsanitary or uncomfortable environmental conditions to ensure the facility is maintained in a manner that is environmentally sound. IV.The facility will monitor the corrective action by implementing the following measures. An environmental safety check list has been put into place and will be used to monitor the facilities environment to ensure it is safe, functional and sanitary. This tool will be used once per week for 4 weeks, once per month for 3 months and the findings will be reported to the Administrator during the Quality Assurance committee meetings. Any discrepancies will be addressed immediately by</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
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	<p>d. Inside base of door to bathroom of room 114 had a hole approximately the size of a grapefruit, exposing wood splinters around edge of hole.</p> <p>e. Floor tile in adjoining bathrooms of rooms 209, 211, 213 and 215 had irregular shaped gouged out areas where tile was missing exposing dirt residue. Areas were anywhere from approximately 1.5 inches to 12 inches long to 1.5 inches to 5 inches wide.</p> <p>On 12/11/14 at 3:30 p.m., the Administrator indicated the bathrooms on the 400 and 500 halls had already been redone, and the facility was planning on doing the bathrooms on the 100 and 200 halls soon.</p> <p>3.1-19(f)</p>		<p>fixing the issues. The frequency will be re-evaluated after the 4 months by the Administrator and will continue at least quarterly thereafter. Any failures to report conditions or resolve known areas will result in further re-education or disciplinary action as needed. V. Plan of Correction completion date. Date of Compliance 01/10/2015 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p>				