

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2014
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NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00151030.</p> <p>Complaint IN00151030-Substantiated. Federal/State deficiencies related to the allegation are cited at F225 and F226.</p> <p>Survey dates: July 7, 8, 9, 10, 11, & 14, 2014</p> <p>Facility number: 000108 Provider number: 155653 Aim number: 100267410</p> <p>Survey Team: Lara Richards, RN-TC Yolanda Love, RN Heather Tuttle, RN (7/7-7/10/14) Cynthia Stramel, RN (7/9-7/11 & 7/14/14) Janelyn Kulik, RN (7/11 & 7/14/14)</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 8</p>	F000000	<p>August 1, 2014 Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006 Dear Ms. Rhoades: Please reference the enclosed 2567L as "Plan of Correction" for the July 14, 2014 Recertification and State Licensure with Complaint (IN00151030) survey that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools August 1, 2014. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on August 1, 2014 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Corrections, please contact me.</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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F000156 SS=C	<p>Medicaid: 61 Other: 1 Total: 70</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 17, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may</p>		Respectfully, Stewart, HFA Neysa				

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	<p>not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy</p>			

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	<p>network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure the residents were aware of who the Ombudsman was and how to contact the Ombudsman. This had the potential to affect the 70 residents who resided in the facility. (Residents #25 and #47)</p> <p>Findings include:</p> <p>Interview with Resident #25 on 7/11/14 at 10:00 a.m., indicated that she did not know who or what the Ombudsman (a resident advocate) was or how to contact the Ombudsman.</p> <p>The Annual MDS (Minimum Data Set) Assessment dated 5/7/14 for Resident</p>	F000156	<p>F156</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p>	08/13/2014

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	<p>#25, indicated a BIMS (Brief Interview for Mental Status) score of 15. This indicated the resident was cognitively intact.</p> <p>Interview with Resident #47 on 7/14/14 at 7:15 a.m., indicated he was not sure who the Ombudsman was initially. The resident then indicated he did know, but information on the Ombudsman had not been discussed in Resident Council meetings since the new Activity Director took over.</p> <p>The Quarterly MDS Assessment dated 4/26/14 for Resident #47, indicated a BIMS score of 15. This indicated the resident was cognitively intact.</p> <p>Review of the Resident Council meeting minutes from January 2014 to June 2014 on 7/11/14 at 12:30 p.m., indicated there was no discussion about the Ombudsman.</p> <p>Interview with the Activity Director on 7/11/14 at 2:33 p.m., indicated he had three pages of information he covered at every Resident Council meeting and it included information about the Ombudsman.</p> <p>Interview with the Activity Director on 7/14/14 at 8:45 a.m., indicated he did not</p>		<p>1. The corrective action taken for the resident found to have been affected by the deficient practice:Resident #25 was given the ombudsman contact information and re-educated on where to find this information in the facility. Resident #47 was not identified on the facility sample resident list. On 7/30/14 cognitive intact residents in the facility were given the Ombudsman contact information and re-informed of where this information can be found in the facility by the Social Service Director.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All resident have the potential to be affected by the deficient practice. No residents were identified as being adversely affected.</p>	

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	<p>document what he discussed at the Resident Council meeting. He did up until the first of the year. He was just writing the same thing over and over again so he stopped documenting what he covered in the meetings.</p> <p>3.1-4(j)(3)(C)</p>		<p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:The Activity Director and Activity staff were in-serviced on 7/22/2014 by the Administrator on informing residents and family members during Resident Council meetings the location and contact information for the Ombudsman.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Activity Director / Designee will monitor Resident Council meeting minutes <u>monthly</u> to ensure that the Ombudsman contact information and location is discussed during the meeting. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for <u>four</u> consecutive</p>	

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F000167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on record review and interview, the facility failed to ensure the residents were aware that the State Inspections were available to read and where it was located. This had the potential to affect the 70 residents residing in the facility. (Residents #25 and #47)</p> <p>Findings include:</p> <p>Interview with Resident #25 on 7/11/14 at 10:00 a.m., indicated that she did not</p>	F000167	<p>months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 08/13/2014</p> <p>F167 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #25 was immediately notified of the location of the most recent survey</p>	08/13/2014

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	<p>know where the survey results were but had never asked for them.</p> <p>The Annual MDS (Minimum Data Set) Assessment dated 5/7/14 for Resident #25, indicated a BIMS (Brief Interview for Mental Status) score of 15. This indicated the resident was cognitively intact.</p> <p>Interview with Resident #47 on 7/14/14 at 7:15 a.m., indicated he was not sure where the survey results were initially. The resident then indicated he did know, but information had not been discussed in Resident Council meetings since the new Activity Director took over.</p> <p>The Quarterly MDS Assessment dated 4/26/14 for Resident #47, indicated a BIMS score of 15. This indicated the resident was cognitively intact.</p> <p>Review of the Resident Council meeting minutes from January 2014 to June 2014 on 7/11/14 at 12:30 p.m., indicated there was no discussion about the past survey results.</p> <p>Interview with the Activity Director on 7/11/14 at 2:33 p.m., indicated he had three pages of information he covered at every Resident Council Meeting.</p>		<p>state inspection book and made aware that the state inspections are available to read. Resident #47 was not identified on facility sample resident list. On 7/30/14 the Social Service Director met 1:1 with cognitively intact residents to re-educate them of where the survey inspection book is located and their rights to review it at any time. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. No residents were identified as being adversely affected. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: The Activity Director and Activity Department were in-serviced on 7/22/2014 by the Administrator regarding the importance of discussing the location of the state survey inspection book and that the state inspections are available to read at each Residential Council meeting. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Activity Director / Designee will monitor Resident Council meeting <u>monthly</u> to ensure the facility residents are informed of the location of the state survey inspection book and that the state inspections are available at any</p>				

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F000225 SS=D	<p>Interview with the Activity Director on 7/14/14 at 8:45 a.m., indicated he did not document what he discussed at the Resident Council meeting. He did up until the first of the year. He was just writing the same thing over and over again so he stopped documenting what he covered in the meetings.</p> <p>3.1-3(b)(1)</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</p>		<p>time to read. Any issues found will be addressed immediately. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for <u>three</u> consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 08/13/2014</p>	

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	<p>through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of misappropriation of resident property was reported to the State Agency within 24 hours for 1 of 3 allegations of abuse reviewed. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 7/9/14 at 2:55 p.m.</p> <p>An entry in the Nursing progress notes dated 8/18/13 at 6:41 a.m., indicated the resident's Physician was notified that the resident had passed away. The resident's brother was informed at 6:44 a.m. The brother indicated he would come to the facility later in the morning to pick up the</p>	F000225	<p>F225</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:Resident B no longer resides in the facility.</p>	08/13/2014

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	<p>resident's belongings. At 11:30 a.m., the family picked up the resident's belongings.</p> <p>Review of the facility record form titled "Customer and Family Concerns" on 7/10/14 at 12:44 p.m., indicated the form was dated 8/18/13. The concern was filed by the resident's brother. The area of concern was "Missing items: cell phone charger and debit card."</p> <p>Documentation on the form indicated the Administrator, Director of Nursing, and Social Services were to be notified.</p> <p>Interview with the Social Service Director on 7/10/14 at 1:50 p.m., indicated the resident's phone charger was found but not the debit card.</p> <p>Review of the facility investigation on 7/10/14 at 2:17 p.m., indicated the Initial Report was faxed to the State Agency on 9/12/13. The description of the incident was the following: "Notified of a potential misappropriation of belongings, time frame is uncertain at this time."</p> <p>Review of the final report faxed to the Stage Agency on 9/17/13 indicated the family arrived at the facility to pick up the resident's personal items. Facility was notified by the family of the resident</p>		<p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: An audit was done on 7/22/14 of any allegations of misappropriation of resident property in the last six months to ensure they were reported to ISDH in a timely manner. No residents were identified as being adversely affected.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:All Department Heads and staff were in-serviced on 7/23/14 by the Administrator on the facility Abuse policy and timely notification of all abuse allegations to the Administrator / Designee.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Administrator / Designee will audit any allegations of abuse to ensure timely reporting to ISDH. Any issues found will be addressed immediately. The</p>	

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	<p>that a car charger and debit card were missing. Family stated they were going to cancel the debit card. Family stated when they canceled the debit card, there was \$32.00 of unauthorized charges. The resident's family filed a report with the local police department.</p> <p>Interview with the Administrator and Social Service Director on 7/10/14 at 2:15 p.m., indicated they were not notified of the debit card missing until September 2013. The Social Service Director indicated that she added the debit card to the concern form dated 8/18/13 but did not put a date on the form when she was notified. She indicated she should have initiated a new form instead of adding the debit card to the previous concern form.</p> <p>Interview with Resident #B's brother on 7/14/14 at 11:20 a.m., indicated the resident's debit card was determined to be missing on the day they came to pick up the resident's belongings on 8/18/13 and staff were informed at this time.</p> <p>This Federal tag relates to Complaint IN00151030.</p> <p>3.1-28(c)</p>		<p>audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the Abuse Prevention Program Policy was followed related to the timely reporting of an allegation of misappropriation of resident property to the State Agency for 1 of 3 allegations of abuse reviewed. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 7/9/14 at 2:55 p.m.</p> <p>An entry in the Nursing progress notes dated 8/18/13 at 6:41 a.m., indicated the resident's Physician was notified that the resident had passed away. The resident's brother was informed at 6:44 a.m. The brother indicated he would come to the</p>	F000226	<p>F226</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p>	08/13/2014
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	<p>facility later in the morning to pick up the resident's belongings. At 11:30 a.m., the family picked up the resident's belongings.</p> <p>Review of the facility record form titled "Customer and Family Concerns" on 7/10/14 at 12:44 p.m., indicated the form was dated 8/18/13. The concern was filed by the resident's brother. The area of concern was "Missing items: cell phone charger and debit card."</p> <p>Review of the facility investigation on 7/10/14 at 2:17 p.m., indicated the Initial Report was faxed to the State Agency on 9/12/13. The description of the incident was the following: "Notified of a potential misappropriation of belongings, time frame is uncertain at this time."</p> <p>Review of the final report faxed to the Stage Agency on 9/17/13 indicated the family arrived at the facility to pick up the resident's personal items. Facility was notified by the family of the resident that a car charger and debit card were missing. Family stated they were going to cancel the debit card. Family stated when they canceled the debit card, there was \$32.00 of unauthorized charges. The resident's family filed a report with the local police department.</p>		<p>1. The corrective action taken for the resident found to have been affected by the deficient practice:Resident B no longer resides in the facility.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: An audit was done on 7/22/14 of any allegations of abuse in the last six months to ensure they were reported to ISDH timely. No residents were identified as being adversely affected.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:All Department Heads and staff were in-serviced on 7/23/14 by the Administrator on the facility Abuse policy and immediate notification of all allegations of abuse to the</p>	

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	<p>Interview with the Administrator and Social Service Director on 7/10/14 at 2:15 p.m., indicated they were not notified of the debit card missing until September 2013. The Social Service Director indicated that she added the debit card to the concern form dated 8/18/13 but did not put a date on the form when she was notified. She indicated she should have initiated a new form instead of adding the debit card to the previous concern form.</p> <p>Interview with Resident #B's brother on 7/14/14 at 11:20 a.m., indicated the resident's debit card was determined to be missing on the day they came to pick up the resident's belongings on 8/18/13 and staff were informed at this time.</p> <p>Review of the facility Abuse Prevention Program Policy on 7/14/14 at 12:15 p.m., which was provided by the Administrator and identified as current, indicated the following: "Initial Reporting of Allegations: The resident's representative and the Department of Public Health shall be informed as soon as possible within 24 hours, but no later than 2 hours if the abuse results in resident injury or harm."</p> <p>This Federal tag relates to Complaint IN00151030.</p>		<p>Administrator / Designee.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Administrator / Designee will audit 100% allegations of abuse to ensure timely reporting to ISDH. The audits will be discussed during our monthly QA meeting. Any issues found will be addressed immediately. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	

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F000279 SS=D	<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 §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). Based on record review and interview,</p>	F000279		08/13/2014
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	<p>the facility failed to ensure each resident had a comprehensive care plan related to weight loss and nutrition for 2 of 3 residents reviewed for nutrition of the 19 residents who met the criteria for nutrition and for foley catheter use for 1 of 3 residents reviewed for urinary catheter use of the 20 residents who met the criteria for urinary catheter use. (Residents #56 and #88)</p> <p>Findings include:</p> <p>1. The record for Resident #56 was reviewed on 7/9/14 at 11:25 a.m. The resident was admitted to the facility on 5/30/14. The resident's diagnoses included, but were not limited to, vascular dementia, dysphagia, and behavioral disturbances with dementia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 6/6/14, indicated the resident was moderately impaired for decision making, and had no delirium or mood issues. The resident needed extensive assist with two person assist with bed mobility and transfers. The resident needed supervision with one person assist with eating. The resident's weight was 162 pounds with no history of weight loss.</p> <p>Review of the monthly weights indicated</p>		<p>F 279</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>The interdisciplinary team reviewed and revised the care plan for R#56 to reflect the Nutrition at Risk plan. The interdisciplinary team reviewed and revised the care plan for R#88 to reflect the foley catheter.</p>	

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	<p>on 6/18/14 the resident weighed 161 pounds. On 6/25/14, the resident weighed 155 pounds. On 7/2/14, the resident weighed 143 pounds and on 7/4/14, the resident weighed 144 pounds.</p> <p>Review of the Registered Dietitian (RD) Progress Note dated 7/9/14, indicated the resident had a 11.1% weight loss times one month. The weight loss was suspected due to hospitalization, decreased meal intake, and refusal of care.</p> <p>Review of the current plan of care dated 7/2014, indicated there was no care plan for the resident's weight loss and nutritional approaches.</p> <p>Interview with the Director of Nursing on 7/10/14 at 2:50 p.m., indicated there was no care plan for the resident's current and recent weight loss.</p> <p>2. The record for Resident #88 was reviewed on 7/9/14 at 9:48 a.m. The resident was admitted to the facility on 2/26/14. The resident's diagnoses included, but were not limited to, post surgical repair of thigh fracture, wound infection, and muscle weakness.</p> <p>Physician orders dated 6/13/14, indicated the resident was on a regular, mechanical soft diet. She received double protein</p>		<p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents with significant weight loss or with foley catheters are at risk for this alleged deficient practice. The interdisciplinary team completed an audit of residents with foley catheters and no other residents were found to be affected by this alleged deficiency. The interdisciplinary team completed an audit of residents with a significant weight loss in the last 60 days and no other residents were affected by the alleged deficiency.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The care plan system was reviewed and revised. During the clinical report meeting the interdisciplinary team will discuss, review and assign updates as indicated. The interdisciplinary team was re-inserviced on updating & formulating care plans</p>	

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F000282 SS=E	<p>and super cereal at breakfast, whole milk with all meals and health shakes with breakfast.</p> <p>A Physician's order dated 5/27/14, indicated the resident had an indwelling Foley catheter to aid with wound healing.</p> <p>There was not a care plan in the resident's record related to nutritional needs nor urinary catheter management.</p> <p>Interview with the MDS Coordinator on 7/14/14 at 10:05 a.m., indicated there were no care plans related to urinary catheter or nutritional needs for this resident. She indicated there should have been care plans in place.</p> <p>3.1-35(a)</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</p>		<p>on 7/31/14.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>The MDS coordinator/designee will audit 10 resident care plans a week for four weeks and then 5 residents 1 time a week for 4 months. The audits will be discussed during our monthly Quality Assurance meeting. The Quality Assurance committee will determine if continued auditing is required once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	

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	<p>written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure Physician Orders were followed as written related to the removal of a dressing to a fistula site used for dialysis for 1 of 1 residents reviewed for dialysis and for supplements not given as ordered for 1 of 3 residents reviewed for nutrition of the 19 residents who met the criteria for nutrition. The facility also failed to ensure the current plan of care was followed as written related to pain assessment and monitoring for 1 of 1 residents reviewed for pain and that range of motion was provided as ordered for 1 of 3 residents reviewed for range of motion of the 9 who met the criteria for range of motion. (Residents #12, #56, #88 and #97)</p> <p>Findings include:</p> <p>1. On 7/7/14 at 10:55 a.m., Resident #97 was observed in bed during a Resident interview. He was noted with a white gauze bandage over his left upper arm. The resident was asked what that was for and he indicated it was his shunt for dialysis. He further indicated it was supposed to be removed after he came back from dialysis, but when he asked the staff, they indicated that was dialysis's job.</p>	F000282	<p>F 282</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1.The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>The charge nurse promptly removed dressing to R #97. DON assessed R#97 with no adverse effects.</p> <p>The c.n.a. informed the nurse of</p>	08/13/2014

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	<p>On 7/9/14 at 9:05 a.m., the resident was observed in bed. The resident was awake and was alert and oriented. He indicated his dialysis days were Tuesdays, Thursdays, and Saturdays. He indicated they usually came to pick him up around 12:00 p.m., or 12:15 p.m. The resident further indicated the staff nurses did not pull the dressing off and assess his access site daily. He indicated the dialysis staff told him the Nursing Home staff were to take the dressing off about 4 to 5 hours after he returned to the facility. He indicated he had told staff that, but they said the Dialysis Center took care of that.</p> <p>On 7/9/14 at 10:15 a.m., the resident was observed in bed. The bandage to the resident's left upper arm was still noted.</p> <p>Interview with LPN #3 at that time, indicated the dressing was to be removed by the midnight shift because the order was for the dressing to be removed eight hours after his return from Dialysis. She further indicated she had just given him his medications and had not even assessed his site yet. The LPN then entered the resident's room and observed the bandage to the left upper arm. She indicated she would remove it immediately.</p>		<p>needing a magic cup on 7/9 and 7/10 and R #56 was provided. The c.n.a. also reported to nurse of needing a skim milk on 7/10 and it was provided. The DON assessed R#56 and he had no adverse effects. The Registered Dietician reviewed his plan of care updating accordingly.</p> <p>The c.n.a provided range of motion and the care plan was updated to reflect resident improvement in range of motion and ability of c.n.a to continue range of motion exercises.</p> <p>The charge nurse had administered pain medication to R#88 and wrote a late entry to document administration. The interdisciplinary team met and reviewed R#88 plan of care and pain management therapy and updated accordingly.</p> <p>1.The corrective action for those residents having the potential to be affected by the same deficient practice:</p>	

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	<p>The record for Resident #97 was reviewed on 7/9/14 at 9:20 a.m. The resident was admitted to the facility on 5/27/14. The resident's diagnoses included, but were not limited to, renal dialysis and end stage renal disease.</p> <p>Review of Physician Orders dated 6/3/14, indicated to remove dressing from dialysis port eight hours after the resident had returned from dialysis once a day Tuesday, Thursday, and Saturday.</p> <p>Review of the Medication Administration Record (MAR) for the month of July 2014, indicated there was no evidence of any documentation the dressing had been removed by Nursing staff. The treatment had not been signed out indicating it had not been completed for 7/1-7/9/14.</p> <p>2. On 7/9/14 at 12:50 p.m., Resident #56 was observed lying in bed. He had just been served his lunch tray. He was served ground meat, potatoes, green beans, brownie, and a carton of skim milk. There was no magic cup (a nutritional supplement) observed on his tray.</p> <p>On 7/10/14 at 9:00 a.m., the resident was observed in bed eating breakfast. At that time, he was served a piece of raisin toast, egg casserole, thickened juice and</p>		<p>R/T R#97 Don completed an audit of residents with orders for dialysis dressing to be removed and no other residents were affected by this alleged deficient practice.</p> <p>R/T R#56 All residents with nutritional supplements are at risk for this alleged deficient practice. The dietary manager completed an audit to ensure physician orders match the tray cards. Any issues were addressed immediately. Staff were re-educated to check meal tray against tray card.</p> <p>R/T R#12 An audit was completed by the restorative team of residents with passive range of motion and plan of care. No other residents were identified as being affected by this alleged deficient practice.</p> <p>R/T R# 88 All residents in pain and residents with wounds are at risk for this alleged deficient practice. Nurses were re-educated administration and on documentation of pain meds. Audit was completed of all residents with wounds and for pain meds being given as ordered</p>	

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	<p>water as well as a bowl of oatmeal. There was no skim milk, nor a magic cup observed on his tray.</p> <p>On 7/10/14 at 12:40 p.m., the resident was observed in bed. He was served his lunch tray. He received ground meat, creamed corn, mashed potatoes, and two cookies. The resident had a red thickened juice and thickened water. The resident did not receive a carton of skim milk nor a magic cup with his lunch.</p> <p>The record for Resident #56 was reviewed on 7/9/14 at 11:25 a.m. The resident was admitted to the facility on 5/30/14. The resident's diagnoses included, but were not limited to, vascular dementia, dysphagia, and behavioral disturbances with dementia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 6/6/14, indicated the resident was moderately impaired for decision making, and had no delirium or mood issues. The resident needed extensive assist with two person assist with bed mobility and transfers. The resident needed supervision and one person assist with eating.</p> <p>Review of Physician Orders dated 7/7/14, indicated a skilled speech therapy diet order, mechanical soft diet no added salt,</p>		<p>and no other residents were identified as being affected by this alleged deficient practice.</p> <p>1.The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>R/T R#97 Nurses were re-educated on 7/23/14 regarding removal of dialysis catheter dressings as ordered. This was placed on the "Pertinent Charting Log" to do list.</p> <p>R/T R#56 Nursing staff were re-educated regarding following plan of care for residents r/t nutritional supplements and checking tray card against meal tray.</p> <p>R/T R#12 Restorative staff were re-educated regarding documentation of range of motion when performed, refusals, and following plan of care.</p>	

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	<p>skim milk, low cholesterol egg, no liver, no sausage, no bacon, with nectar thick liquids, magic cup with all meals.</p> <p>Interview with LPN #3 on 7/9/14 at 1:40 p.m., indicated she received the order for the magic cup supplement on 7/7/14.</p> <p>3. On 7/11/14 at 8:32 a.m., Resident #12, was observed in bed. He was laying on his back and slightly to his left side. He was covered with a sheet and there were no staff in the room. The resident indicated at this time, that he did not have his splints in his hands. He indicated staff put them in his hands and they do it almost everyday.</p> <p>On 7/11/14 at 11:13 a.m., the resident indicated he had splints in his bilateral hands. He indicated the Restorative Aide moved his fingers before they put the splints in his hands and moved his right leg.</p> <p>On 7/14/14 at 9:53 a.m., Resident #12 was observed in bed with Restorative Aide #1 at his side. The Restorative Aide had a hold of the resident's left hand. She indicated at this time that she had already done the range of motion (ROM). She then demonstrated what she did by gently opening and closing the resident's hand and indicated that was how she did the range of motion. The Restorative Aide</p>		<p>R/T R#88- Nurses were re-educated on 7/23/14 regarding, administration of pain meds and documentation.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>The treatment nurse will monitor the removal of dialysis dressing 2 days a week for four weeks. Then 1 time a week for 4 months.</p> <p>The Dietary Manager will audit 10 meal trays 5 days per week for 4 weeks</p> <p>Then 20 trays weekly for 4 months.</p> <p>Restorative Nurse will monitor 5 residents on Passive range of motion programs weekly for 4 weeks. Then 3 weekly for 4 months.</p>	

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	<p>then placed the splint in the resident's left hand and did the same to the resident's right hand.</p> <p>The record for Resident #12 was reviewed on 7/11/14 at 9:19 a.m. The resident's diagnoses included, but were not limited to, quadriplegia, chronic pain, osteoporosis, and muscle spasms.</p> <p>A care plan with the problem of resident has limitations to upper and lower extremity and required staff assist with ROM (range of motion). The care plan was initiated on 9/5/13. The goal indicated the resident would tolerate PROM (passive range of motion) to his bilateral hands and right foot, 20 repetitions (reps) thru next review. The approaches included, but were not limited to, PROM to bilateral hands and right foot using flexion and extension 20 reps daily, 6-7 days a week, staff to notify nurse if resident showed signs of distress during exercises, explain the procedure to resident, staff to inspect affected joint and report any findings to nurse, staff to notify PT/OT (Physical and Occupational Therapy) if resident shows further decrease in joint mobility.</p> <p>Review of the Nursing Rehab time log for the past month, indicated the resident received or was attempted to be given 15</p>		<p>DON/designee will monitor 5 residents with pain meds ordered 5 times week for 4 weeks. Then 15 residents weekly for 4 months.</p> <p>The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	

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	<p>minutes of PROM. There was no range of motion documented from 6/27 to 6/29/14 and from 7/1 to 7/5/14.</p> <p>Interview with Restorative Aide #1 on 7/14/14 at 9:53 a.m., indicated she does do range of motion prior to putting the resident's splints on. She further indicated she does 3 sets of 15. She indicated she was informed this was the number of repetitions she was to give the resident.</p> <p>Interview with the MDS Coordinator on 7/14/14 at 10:59 a.m., indicated that Restorative should have been doing 20 repetitions and Resident #12 should have had ROM 6-7 days per week. Staff were to document if the resident refused which they did on someday's. The MDS Coordinator indicated there may have been computer issues but the Restorative Aide should have told her about the issues.</p> <p>4. On 7/10/14 at 9:35 a.m., Resident #88's dressing change was observed with the Wound Care Nurse. The Nurse positioned the resident on her right side in the bed to do the dressing change to her buttocks. The resident was observed grimacing and complained it hurt to be on the right side. The Wound Nurse completed the treatment. She offered to get the resident up to the wheelchair, the</p>			

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	<p>resident indicated it hurt to sit in the wheelchair.</p> <p>The record for Resident #88 was reviewed on 7/9/14 at 9:48 a.m. The resident was admitted to the facility on 2/26/14. The resident's diagnoses included, but were not limited to, post surgical repair of thigh fracture, wound infection, and muscle weakness.</p> <p>The Minimum Data Set (MDS) Admission Assessment dated 3/6/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 14, which indicated she was cognitively intact.</p> <p>A care plan dated 3/22/14 was for potential for pain. The goal indicated the resident would experience relief of pain by verbal response. Approaches included to administer pain medication per Physician order and observe effectiveness of medication, keep the Physician informed of the resident's condition, and assess and document the origin, duration, frequency and intensity of the pain.</p> <p>A Physician order dated 5/25/14, indicated the resident was to receive Acetaminophen (Tylenol) 650 milligrams (mg) every 6 hours prn (as needed).</p>			

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	<p>A Physician order dated 6/4/14, indicated the resident was to receive Tramadol (a pain medication) 50 mg every 6 hours prn.</p> <p>Interview with LPN #1 on 7/10/14 at 10:10 a.m., indicated she had given the resident a Tramadol at 8:00 a.m. before she was repositioned. She indicated it hurt the resident to be turned, so she would often give pain medication prior to repositioning.</p> <p>Review of the resident's Medication Administration Record (MAR) for July 2014, indicated the resident did not have any Tramadol documented as given for the month. The PRN Flowsheet was also blank.</p> <p>The Nursing progress note dated 7/10/14 at 9:51 a.m., indicated the resident had no complaints of pain or discomfort. There was no previous documentation of resident pain, or pain medication given.</p> <p>Interview with the Director of Nursing (DoN) on 7/10/14 at 2:40 p.m., indicated prn pain medication was to be documented on the flow sheet, then followed up on in 30 minutes to see if it was effective.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services related to changing the gauze bandage on a fistula shunt used for dialysis for 1 of 1 residents reviewed for dialysis. The facility also failed to ensure 1 of 1 residents reviewed for pain were assessed and monitored for pain management. (Residents #88 and #97)</p> <p>Findings include:</p> <p>1. On 7/7/14 at 10:55 a.m., Resident #97 was observed in bed during a Resident interview. He was noted with a white gauze bandage over his left upper arm. The resident was asked what that was for and he indicated it was his shunt for dialysis. He further indicated it was supposed to be removed after he came back from dialysis, but when he asked staff they indicated that was dialysis's</p>	F000309	<p>F 309 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: The charge nurse promptly removed dressing to R #97. DON assessed R#97 with no adverse effects. The charge nurse had administered pain medication to R#88 and she wrote a late entry to document administration. The interdisciplinary team met and reviewed R#88 plan of care and pain management and updated accordingly. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: R/T R#97 Don completed an audit of residents with orders for dialysis</p>	08/13/2014			

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	<p>job.</p> <p>On 7/9/14 at 9:05 a.m., the resident was observed in bed. The resident was awake and was alert and oriented. He indicated his dialysis days were Tuesdays, Thursdays, and Saturdays. He indicated they usually came to pick him up around 12:00 p.m., or 12:15 p.m. The resident further indicated the staff nurses do not pull the dressing off and assess his access site daily. He indicated the dialysis staff told him the Nursing Home staff were to take the dressing off about 4 to 5 hours after he returned to the facility. He indicated he had told staff that, but they said the Dialysis Center took care of that.</p> <p>On 7/9/14 at 10:15 a.m., the resident was observed in bed. The bandage to the resident's left upper arm was still noted.</p> <p>Interview with LPN #3 at that time, indicated the dressing was to be removed by the midnight shift because the order indicated the dressing was to be removed eight hours after his return from Dialysis. She further indicated she had just given him his medications and had not even assessed his site yet. The LPN then entered the resident's room and observed the bandage to the left upper arm. She indicated she would remove it immediately.</p>		<p>dressing to be removed and no other residents were affected by this alleged deficient practice. All residents on prn pain medication therapy and wounds are at risk for this alleged deficient practice. Nurses were re-educated concerning administration and documentation of pain meds. An audit was completed of all residents with wounds for pain medication administration as indicated and no other residents were identified to be at risk. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Nurses were re-educated on 7/23/14 regarding removal of dialysis catheter dressings as ordered. Nurses were re-educated on 7/23/14 regarding administration of pain meds and documentation as it pertains to this alleged deficient practice. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: The treatment nurse will monitor the removal of dialysis dressing 2 days a week for four weeks. Then 1 time a week for 4 months. DON/designee will monitor 5 residents with pain meds ordered 5 times week for 4 weeks. Then 15 residents weekly for 4 months. The audits will be discussed during our monthly Quality Assurance meeting. The Quality Assurance committee will</p>				

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	<p>The record for Resident #97 was reviewed on 7/9/14 at 9:20 a.m. The resident was admitted to facility on 5/27/14. The resident's diagnoses included, but were not limited to, renal dialysis and end stage renal disease.</p> <p>Review of the Minimum Data Set (MDS) Admission Assessment dated 6/3/14, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident needed extensive assist with a two person physical assist for transfers. The resident was receiving dialysis.</p> <p>Review of the 6/8/14 plan of care, indicated the resident required hemodialysis secondary to renal failure and was at risk for complications. The Nursing approaches were hemodialysis as ordered by the Physician, observe for increased blood pressure, weight gain, edema, shortness of breath, dyspnea, and congestive heart failure, observe Arteriovenous (AV) shunt for signs of inadequate blood flow or bleeding at site.</p> <p>Review of Physician Orders dated 6/3/14, indicated remove dressing from dialysis port eight hours after resident had returned from dialysis once a day Tuesday, Thursday, and Saturday.</p>		determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 8/13/14	

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	<p>Review of Nursing Progress Notes dated 6/3/14, indicated writer received order for nurse at facility to remove dressing from left AV shunt eight hours after resident returns from dialysis. The resident was informed.</p> <p>Review of the Medication Administration Record (MAR) for the month of July 2014, indicated there was no evidence of any documentation the dressing had been removed by Nursing staff. The treatment had not been signed out, indicating it had not been completed for 7/1-7/9/14.</p> <p>2. On 7/9/14 at 3:25 p.m., Resident #88 was observed laying in her bed on her back. Her knees were in a contracted position, a brace was on the left knee. She complained of her legs hurting, and indicated she had received a pain pill.</p> <p>On 7/10/14 at 9:35 a.m., the resident's dressing change was observed with the Wound Care Nurse. The Nurse positioned the resident on her right side in the bed to do the dressing change to her buttocks. The resident was observed grimacing and complained it hurt to be on the right side. The Wound Nurse completed the treatment. She offered to get the resident up in the wheelchair, the resident indicated it hurt to sit in the wheelchair.</p>			

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	<p>The record for Resident #88 was reviewed on 7/9/14 at 9:48 a.m. The resident was admitted to the facility on 2/26/14. The resident's diagnoses included, but were not limited to, post surgical repair of thigh fracture, wound infection, and muscle weakness.</p> <p>The Minimum Data Set (MDS) Admission Assessment dated 3/6/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 14, which indicated she was cognitively intact.</p> <p>A care plan dated 3/22/14 was for potential for pain. The goal indicated the resident will experience relief of pain by verbal response. Approaches included to administer pain medication per Physician order and observe effectiveness of medication, keep the Physician informed of the resident's condition, and assess and document the origin, duration, frequency and intensity of the pain.</p> <p>A Physician order dated 5/25/14, indicated the resident was to receive Acetaminophen (Tylenol) 650 milligrams (mg) every 6 hours prn (as needed).</p> <p>A Physician order dated 6/4/14, indicated the resident was to receive Tramadol (a</p>			

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	<p>pain medication) 50 mg every 6 hours prn.</p> <p>Interview with LPN #1 on 7/10/14 at 10:10 a.m., indicated she had given the resident a Tramadol at 8:00 a.m. before she was repositioned. She indicated it hurt the resident to be turned, so she would often give pain medication prior to repositioning.</p> <p>Review of the resident's Medication Administration Record (MAR) for July 2014, indicated there was no Acetaminophen or Tramadol documented as being given for the month. The prn flow sheet was also blank.</p> <p>Nursing progress notes dated 7/9/14, did not have any documentation of pain medication given nor complaints of pain.</p> <p>Nursing progress notes dated 7/10/14 at 9:51 a.m., indicated the resident had no complaints of pain or discomfort. There was no previous documentation of resident pain, or pain medication given.</p> <p>Interview with the Director of Nursing (DoN) on 7/10/14 at 2:40 p.m., indicated prn pain medication was to be documented on the flow sheet, then followed up on in 30 minutes to see if it was effective.</p>			

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F000312 SS=D	<p>The policy Pain Assessment was received from the DoN on 7/14/14 at 8:40 a.m. The policy indicated, "Pain will be assessed and documented at regular intervals. Evaluation of the effectiveness of analgesic medication in relieving pain should be performed consistent with facility protocol." The policy also indicated the Physician should be notified of unrelieved pain.</p> <p>3.1-37(a)</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, record review, and interview, the facility failed to provide Activities of Daily Living (ADL) assistance to a dependant resident related to providing showers as scheduled for 1 of 3 residents reviewed for Choices of the 5 residents who met the criteria for Choices. (Resident #97)</p> <p>Findings include: On 7/07/14 at 10:53 a.m., Resident #97</p>	F000312	<p>F 312</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not</p>	08/13/2014

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	<p>was interviewed. At that time, he indicated he had only received one shower since he had been at the facility. He further indicated he would like to take more than just one shower a week, "even to have two a week would be great."</p> <p>On 7/9/14 at 9:05 a.m., the resident was observed in bed. He indicated he only recalled receiving one shower since he had been at the facility.</p> <p>The record for Resident #97 was reviewed on 7/9/14 at 9:20 a.m. The resident was admitted to facility on 5/27/14. The resident's diagnoses included, but were not limited to, renal dialysis, diabetes, contracture, blindness, impairment one eye, below the knee amputation of the left leg, polyneuropathy, muscle weakness, congestive heart failure, and end stage renal disease.</p> <p>Review of the Minimum Data Set (MDS) Admission Assessment dated 6/3/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident needed extensive assist with two person physical assist for transfers. He was limited assist with one person physical assist for bed mobility and needed physical help with one person</p>		<p>constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>R# 97 received a shower on 7/9/14.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents that consent to showers are @ risk for this alleged deficient practice. Audit was completed during survey to ensure that all residents were listed on the shower schedule. No</p>	

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	<p>assist for bathing.</p> <p>Review of the current plan of care dated 6/8/14, indicated the resident required staff assist with ADL's. The Nursing approaches were to assist the resident as needed.</p> <p>Review of the shower schedule indicated the resident's shower days were on Mondays and Thursdays.</p> <p>Review of the shower sheet indicated the resident received a shower on 6/2 and 6/9/14. The resident had not received any showers for the month of July 2014.</p> <p>Interview with CNA #8 on 7/9/14 at 9:40 a.m., indicated he did not personally give the resident a shower, but he followed behind the CNA to make sure a shower was given.</p> <p>Interview with the Director of Nursing on 7/9/14 at 10:00 a.m., indicated the shower ADL sheet on the computer, in the point of care report, indicated the resident only received a shower two times since admission. There was no other documentation to indicate the resident refused his showers.</p> <p>3.1-38(a)(2)(A)</p>		<p>residents were found to be affected by this alleged deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>Nursing staff were re-inserviced regarding shower schedule and documentation. This was completed during survey & on 7/23/14.</p> <p>Shower schedule was updated.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Treatment Nurse will monitor 5 showers daily 4-5 days a week for four weeks. Then 15 showers a week for 4 months.</p> <p>The audits will be discussed during our monthly QA meeting.</p>	

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure cross contamination of a wound did not occur while completing a dressing change for 1 of 3 residents reviewed for pressure sores of the 5 who met the criteria for pressure sores. (Resident #27)</p> <p>Findings include:</p>	F000314	<p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p> <p>F 314</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as</p>	08/13/2014

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	<p>On 7/11/14 at 9:39 a.m., the Treatment Nurse was preparing to complete the Wound Vacuum dressing change for Resident #27. The resident was identified as being in contact isolation for ESBL (Extended spectrum beta-lactamase) to her Stage 4 (full thickness tissue loss) pressure ulcers. Prior to entering the room, the Treatment Nurse put on a yellow isolation gown and a head covering. Upon entering the room, the Treatment Nurse washed her hands with soap and water and applied a pair of gloves.</p> <p>At this time, the resident was in her bed positioned on top of an incontinence pad. The Treatment Nurse proceeded to position the resident on her right side and her incontinence brief was unfastened. A large dressing was in place to the resident's coccyx and buttock region. At this time, the dressing was removed and the nurse proceeded to clean the pressure ulcers to the left ischium, coccyx, and right ischium with Dakin's solution (a solution used to treat and prevent skin and tissue infections). After cleaning the areas, the nurse inserted a gauze pad into each wound to keep them covered.</p> <p>The nurse then proceeded to remove the gauze packing from the left ischial wound and apply a thin strip of</p>		<p>the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>The treatment nurse completed an assessment of the wound and resident and there were no adverse effects. The DON immediately inserviced the treatment nurse on infection control and hand washing.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents with wounds were assessed by treatment nurse during survey and they showed</p>	

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	<p>hydrocolloid (a type of dressing) to the wound edges. The wound was left open to air at this time. The nurse proceeded to remove her gloves and apply a new pair of gloves, she did not use an alcohol based hand gel in between glove changes. The gauze was removed to the right ischial wound and hydrocolloid was applied to the wound edges. The wound was left open to air at this time. After applying the hydrocolloid to the right ischial ulcer, the nurse removed her gloves and applied a new pair of gloves. She did not use an alcohol based hand gel in between the glove change. An opsite transparent dressing was applied to the outside edges of the right ischial ulcer, the left ischial ulcer remained opened to air at this time. The nurse proceeded to remove the gauze from the coccyx wound and apply an opsite transparent dressing to the wound edges and surrounding intact skin. After changing her gloves and using an alcohol based hand gel, the nurse applied new gloves and proceeded to fold over the edge of the incontinence pad and placed a paper towel on top of the pad with cut out sections of opsite dressings. The nurse proceeded to place opsite dressings around the 3 wounds and surrounding skin. The resident's wounds remained open to air at this time. The nurse then proceeded to cut the foam wound vacuum sponges to size. The</p>		<p>no indication that they had been effected by this alleged deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The KCI Wound Consultant is scheduled to come 8/7/14 and re-educate the Treatment Nurse 1:1 on Infection Control and Hand washing related to wound care. Nursing Staff were reeducated on Infection Control and Hand Washing on 7/23/14 by DON.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>The DON/Designee will monitor treatment nurse for 3 treatments weekly for four weeks. Then will monitor 1 treatment a week for 4 months. The audits will be discussed during our monthly Quality Assurance meeting. Quality Assurance committee will determine if continued auditing is</p>	

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	<p>nurse removed her old gloves and applied a new pair of gloves without using an alcohol based hand gel in between the glove change. The nurse placed the foam sponges inside the plastic of the wrapper and placed them on top of the resident's bed at this time. The nurse then proceed to insert the foam sponges into each wound and cover the areas with opsite prior to turning on the wound vacuum.</p> <p>The record for Resident #27 was reviewed on 7/10/14 at 10:34 a.m. The resident's diagnoses included, but were not limited to, Stage 4 pressure ulcer to the coccyx, left and right ischium, and wound infection resistant to drugs.</p> <p>Physician's orders dated 7/7/14, indicated the resident was to be placed in contact isolation for ESBL of wound and Invanz (an antibiotic) was to be given intravenously (IV) for 14 days.</p> <p>Interview with the Director of Nursing (DoN) on 7/14/14 at 1:10 p.m., indicated the Treatment Nurse should have at least used hand gel in between each glove change. The DoN also indicated the Wound Care Nurse should have left each wound covered as much as possible to avoid cross contamination.</p> <p>3.1-40(a)(2)</p>		<p>necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	

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F000318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, record review and interview the facility failed to ensure each resident received range of motion services related to passive range of motion for 1 of 3 residents reviewed for range of motion of the 9 who met the criteria for range of motion. (Resident #12)</p> <p>Finding include:</p> <p>On 7/11/14 at 8:32 a.m., Resident #12, was observed in bed. He was laying on his back and slightly to his left side. He was covered with a sheet and there were no staff in the room. The resident indicated at this time, that he did not have his splints in his hands. He indicated staff put them in his hands and they do it almost everyday.</p>	F000318	<p>F 318 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Restorative aide did provide passive range of motion for resident during survey. R #12 has had improvement in his range of motion so the care plan was updated to reflect. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: Any residents with contractures are at risk for this alleged deficient practice. The restorative nurse audited residents in passive</p>	08/13/2014

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	<p>On 7/11/14 at 11:13 a.m., the resident indicated he had splints in his bilateral hands. He indicated the Restorative Aide moved his fingers before they put the splints in his hands and moved his right leg.</p> <p>On 7/14/14 at 9:53 a.m., Resident #12 was observed in bed with Restorative Aide #1 at his side. The Restorative Aide had a hold of the resident's left hand. She indicated at this time that she had already done the range of motion (ROM). She then demonstrated what she did by gently opening and closing the resident's hand and indicated that was how she did the range of motion. The Restorative Aide then placed the splint in the resident's left hand and did the same to the resident's right hand.</p> <p>The record for Resident #12 was reviewed on 7/11/14 at 9:19 a.m. The resident's diagnoses included, but were not limited to, quadriplegia, chronic pain, osteoporosis, and muscle spasms.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment dated 5/22/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15. This indicated he was cognitively intact. He had impairment to both sides of his upper extremity and impairment to both sides of</p>		<p>range of motion programs and promptly addressed issues. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Restorative aides were re-educated on documentation of passive range of motion and following plan of care by Restorative nurse on 7/16/14. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Restorative nurse will monitor 1 resident daily 4-5 days a week for four weeks. Then 3 residents weekly for 4 months. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 8/13/14</p>	

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	<p>his lower extremity. He used no mobility devices.</p> <p>A care plan with the problem of resident has limitations to upper and lower extremity and required staff assist with ROM (range of motion). The care plan was initiated on 9/5/13. The goal indicated the resident would tolerate PROM (passive range of motion) to his bilateral hands and right foot, 20 repetitions (reps) thru next review. The approaches included, but were not limited to, PROM to bilateral hands and right foot using flexion and extension 20 reps daily, 6-7 days a week, staff to notify nurse if resident showed signs of distress during exercises, explain the procedure to resident, staff to inspect affected joint and report any findings to nurse, staff to notify PT/OT (Physical and Occupational Therapy) if resident shows further decrease in joint mobility.</p> <p>Restorative Nursing Program Documentation dated 5/19/14 at 12:45 p.m. indicated range of motion, the resident needs this program to maintain current level of joint mobility. The resident was maintaining his level of joint mobility. The resident was able to participate in this program with staff assistance. The resident will tolerate PROM (Passive Range of Motion) to</p>			

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	<p>bilateral hands and right foot 20 reps. The Resident was maintaining PROM ability with staff assistance, the resident was cooperative. Resident tolerated PROM to bilateral hands and right foot 20 reps. The resident had PROM to bilateral hands and right foot using flex and ext times 20 reps daily 6-7 days a week. The resident was given rest periods as needed. The resident had not c/o (complained/of) pain or discomfort during or post exercise. The Resident had not developed any decline in joint mobility in comparison to his previous assessment.</p> <p>Review of Nursing notes from January 2014 thru July 11, 2014, indicated there were no issues noted with passive range of motion.</p> <p>Review of the Nursing Rehab time log for the past month, indicated the resident received or was attempted to be given 15 minutes of PROM. There was no range of motion documented from 6/27 to 6/29/14 and from 7/1 to 7/5/14.</p> <p>Interview with Restorative Aide #1 on 7/14/14 at 9:53 a.m., indicated she does do range of motion prior to putting the resident's splints on. She further indicated she does 3 sets of 15. She indicated she was informed this was the</p>			

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F000323	<p>number of repetitions she was to give the resident.</p> <p>Interview with the MDS Coordinator on 7/14/14 at 10:59 a.m., indicated that Restorative should have been doing 20 repetitions and Resident #12 should have had ROM 6-7 days per week. Staff were to document if the resident refused which they did on someday's. The MDS Coordinator indicated there may have been computer issues but the Restorative Aide should have told her about the issues.</p> <p>Interview with the MDS Coordinator on 7/14/14 at 11:52 a.m., indicated the Restorative Aides were told the number of repetitions the resident was to receive for ROM. She indicated she made a spread sheet for the aides.</p> <p>3.1-42(a)(2)</p> <p>483.25(h)</p>				

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SS=D	<p>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure each resident was supervised related to dining and thickened liquids for 1 of 3 residents reviewed for nutrition of the 19 residents who met the criteria for nutrition. (Resident #56)</p> <p>Findings include:</p> <p>1. On 7/9/14 at 12:50 p.m., Resident #56 was observed in bed eating lunch by himself. The resident was served ground meat, potatoes, green beans, and a brownie. The resident was served a carton of skim milk. He also was observed to have two glasses of thickened orange juice and water. The resident was then observed drinking the skim milk from the carton with a straw. At that time, the milk was not thickened and there was no other staff in the room with the resident. Continued observation on 7/9/14 at 1:10 p.m., indicated the resident had finished his meal. CNA #5 came into the room to pick up his tray.</p> <p>Interview with CNA #5 at that time,</p>	F000323	<p>F 323</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1.The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>Resident # 56 was assessed by DON and had no adverse effects</p>	08/13/2014
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	<p>indicated she had heard the speech therapist said it was ok to give the resident thin liquids because he likes them better and does not like the thickened liquids.</p> <p>On 7/10/14 at 9:00 a.m., the resident was observed in bed eating breakfast. At that time, the resident was observed with a plastic cup of unthickened water in which he had been drinking. Continued observation at that time, indicated there was no staff in the room monitoring the resident while he ate and drank his meal.</p> <p>The record for Resident #56 was reviewed on 7/9/14 at 11:25 a.m. The resident was admitted to the facility on 5/30/14. The resident's diagnoses included, but were not limited to, vascular dementia, dysphagia, and behavioral disturbances with dementia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 6/6/14, indicated the resident was moderately impaired for decision making, and had no delirium or mood issues. The resident needed extensive assist with two person assist with bed mobility and transfers. The resident needed supervision and one person assist with eating.</p> <p>Review of the current plan of care</p>		<p>from alleged deficiency. Physician orders and care plan were updated.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents on thickened liquids are at risk for this alleged deficient practice. The DON completed an audit during survey of all residents on thickened liquids and no other residents were identified as being affected by this alleged deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The nursing staff were reeducated on 7/23/14 regarding supervision. The interdisciplinary team reviewed the Thick Liquid procedure. A list is kept in the "care alert book" of residents on thickened liquids. The list will be updated by DON/designee as changes occur.</p>	

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	<p>indicated there was no care plan available for review for thickened liquids.</p> <p>Review of the current Physician Orders dated 7/7/14, indicated mechanical soft diet with nectar thick liquids.</p> <p>Review of the Speech Therapy Progress Note dated 6/17/14, indicated the resident was evaluated for dysphagia.</p> <p>A Speech Therapy Progress Note dated 6/24/14, indicated the resident was easily agitated and uncooperative. His current diet was pureed and nectar thick liquids. The resident insisted on eating in bed frequently while side lying with only moderate head elevation. The resident had complaints about the texture of the solids and liquids. The resident seldom drinks any of the thickened liquids.</p> <p>A Speech Therapy Progress Note dated 6/30/14, indicated the resident was evaluated at the bedside. Resident had pureed meal at bedside but refused to eat any of it. He also declined his thickened liquids.</p> <p>The last Speech Therapy Progress Note was dated 7/7/14, which indicated the resident was treated at the bedside. He will generally take small bites of his meal. No trouble chewing noted and</p>		<p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>DON / Designee will monitor 2 residents 5 days a week for four weeks. Then audit will continue with 5 residents a week for 4 months. The audits will be discussed during our monthly Quality Assurance meeting.</p> <p>Quality Assurance committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14.</p>	

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F000325 SS=G	<p>clears throat after 50% of his swallows. Continue on nectar thick liquids but consumes very little of it. Also clears throat after swallowing liquids.</p> <p>Interview with the Speech Therapist on 7/10/14 at 3:15 p.m., indicated she had not recommended the resident to receive thin liquids. She indicated her recommendation was for nectar thick liquids.</p> <p>Interview with the Director of Nursing on 7/10/14 at 2:50 p.m., indicated the resident was to receive thickened liquids. She further indicated the resident should not have been given thin liquids without supervision.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to provide</p>	F000325	F 325	08/13/2014			

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	<p>acceptable parameters of nutrition related to providing supplements as ordered by the Physician for 3 of 3 residents reviewed for nutrition of the 19 residents who met the criteria for nutrition and for ensuring a resident who received dialysis was provided a lunch before leaving for 1 of 1 residents reviewed for dialysis. The facility also failed to ensure Registered Dietitian (RD) recommendations were implemented, supplement intake was monitored, and a resident was being monitored in Nutrition at Risk Meetings. This resulted in the resident not being monitored for a 15.5% weight loss and being below her recommended body mass index (BMI). (Residents #56, #88 and #97)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The record for Resident #88 was reviewed on 7/9/14 at 9:48 a.m. The resident was admitted to the facility on 2/26/14. The resident diagnoses included, but were not limited to, post surgical repair of thigh fracture, wound infection, and muscle weakness. <p>The Minimum Data Set (MDS) Admission Assessment dated 3/6/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 14, which indicated she was cognitively</p>		<p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>The c.n.a informed the nurse of needing a health shake and one was provided to resident. The registered dietician spoke with R#88 during survey. Her likes and dislikes were discussed as well as her supplement preferences. R#88 plan of care was reviewed by the interdisciplinary team and revised accordingly. R#88 continues to be monitored by the Nutrition at Risk Committee.</p>	

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	<p>intact. Her functional status indicated she needed extensive assistance with bed mobility and transferring. She had no or unknown significant weight loss or gain in the six months prior to admission. Her weight was 129 pounds and her BMI (Body Mass Index) on admission was 22.8, which was within normal range.</p> <p>On 7/10/14 at 9:00 a.m., the resident's breakfast tray was observed being removed from her room. The super cereal had not been touched.</p> <p>On 7/10/14 at 12:40 p.m., a staff member removed the resident's lunch tray from her room. There was no health shake on the tray or in the resident's room. CNA #4 indicated she did not get the resident her health shake and would notify the nurse.</p> <p>On 7/11/14 at 12:50 p.m., the lunch tray was removed from the resident's room. The health shake was on the cart but had not been opened.</p> <p>On 7/14/14 at 8:50 a.m., the breakfast tray was removed from the room. Only one bite of super cereal had been taken.</p> <p>The resident's weights were as follows: 2/27/14 129 pounds 3/6/14 124 pounds</p>		<p>The facility staff delivered a "bag lunch" to R 97 at dialysis on 7/10/14. The Dietary manager met with R 97 to review his preference for meals on dialysis days.</p> <p>The c.n.a informed the nurse of needing a magic cup and skim milk. This was provided for R#56. R #56 continues in Nutrition at Risk for monitoring.</p> <p>The Dietary Manager reviewed meal preferences, likes/dislikes with R # 88, 56 & 97 and updated accordingly.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents that trigger at risk nutritionally are at risk for this alleged deficient practice.</p> <p>The interdisciplinary team audited dietary recommendations for the</p>	

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	<p>3/12/14 125 pounds 3/27/14 118.4 pounds 4/10/14 115.4 pounds 5/3/14 112.8 pounds 6/5/14 111.4 pounds 7/10/14 109 pounds</p> <p>The resident had a 20 pound weight loss in less than 6 months, resulting in a significant weight loss of 15.5%.</p> <p>Physician diet orders dated 6/13/14, indicated the resident received a regular, mechanical soft diet with double protein and super cereal at breakfast. Whole milk with all meals and health shake with lunch.</p> <p>A Dietary Progress note dated 3/13/14, indicated the resident reported drinking the health shakes and had a good appetite. A 4 pound weight loss was noted, continue to monitor oral intake.</p> <p>A Dietary Progress note dated 4/10/14, indicated the resident received double protein and health shakes twice daily, recommend adding super cereal to address weight loss.</p> <p>A Dietary Progress note dated 5/14/14, indicated the resident had been referred to the RD due to weight loss. The resident's current weight was 112.8</p>		<p>months of May, June and July and no further alleged deficiencies were identified.</p> <p>All residents on dialysis that are out of the building during meal times are at risk for this alleged deficient practice. Dietary Manager spoke with staff and residents to ensure that their preference as to either a "bag lunch" "early tray" or a "saved tray" are honored.</p> <p>3. The measures put into place and a systemic change made to</p>	

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	<p>pounds, her BMI was 19.9% which was below desirable range. The RD recommended weekly weights for closer monitoring.</p> <p>A Dietary Progress note dated 6/11/14, indicated the resident's current BMI was below desirable range at 19.7%. The resident was receiving health shake, double protein and super cereal. The resident reported her appetite was good.</p> <p>Interview with MDS Coordinator on 7/10/14 at 12:45 p.m., indicated the resident had been put on NARS (Nutrition At Risk) on 3/6/14 after her initial weight loss. She was taken off NARS on 4/10/14 because she did not have a significant weight loss that month. She indicated the weekly weights recommended by the RD on 5/14/14 had not been implemented. She indicated the CNA's would document how much each resident ate for each meal. They did not document health shakes, double protein or super cereal specifically. NARS relied on Nursing staff to let them know if the resident was eating the supplements provided. She was not aware the resident was not eating super cereal or health shakes.</p> <p>Further interview with the MDS Coordinator on 7/14/14 at 10:05 a.m.,</p>		<p>ensure the deficient practice not reoccur:</p> <p>The interdisciplinary team reviewed the nutritional intake system. The staff was reeducated on recording the percentage that was consumed at meal time. The interdisciplinary team will monitor for compliance and review during the Nutrition at Risk meeting.</p> <p>The dietary manager spoke with staff and residents that go out on a regular basis to ensure that resident preference as to either a "bag lunch" "early tray" or a "saved tray" are honored.</p> <p>The nursing staff was reeducated on 7/23/14 concerning the serving, offering & documentation of dietary supplements and meals for dialysis residents as per plan of care.</p> <p>The dietary staff was re-educated on 7/29/14 concerning providing the dietary supplements on resident trays as ordered.</p>	

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	<p>indicated there was not a nutritional care plan for the resident. She indicated there should have been a care plan in place. 2. Interview with Resident #97 on 7/9/14 at 9:05 a.m., indicated his dialysis days were Tuesdays, Thursdays, and Saturdays. He further indicated the ambulance company usually came to pick him up around 12:15 p.m. or 12:30 p.m. He indicated he did not always get a hot lunch before he left. He indicated he usually comes back to the facility around 5:30 p.m., and then eats supper.</p> <p>On 7/10/14 at 12:12 p.m., the resident was observed in his bed. His head was under the blankets. He indicated he had not been offered lunch at that time. He indicated no staff had been in to give him his hot lunch before he left for dialysis.</p> <p>Continued observation on 7/10/14 at 12:15 p.m., indicated the ambulance service had arrived to take the resident to dialysis. The resident had not had lunch at that time.</p> <p>Further observation at 7/10/14 at 12:22 p.m., indicated the resident was observed on the stretcher ready to go to dialysis. At that time, one of the attendants came up to the Nurses' station and asked LPN #3 if the resident had a lunch to go. The nurse shook her head no and stated, "He</p>		<p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>The DON/Designee/Dietary Manager will monitor at least 5 resident meal trays daily for four weeks. Then will continue audits of at least 10 residents a week for 4 months.</p> <p>The dietary manager will audit 50% of residents who that go out on pass routinely for 4 weeks. Then 25% of residents who go out on pass routinely a week for 4 months.</p> <p>The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	

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	<p>usually does not eat lunch." The LPN then yelled over to the resident and asked him if he wanted a lunch and he said "that was ok." The attendants then left with the resident.</p> <p>Interview with LPN #3 at that time, indicated they save the resident's lunch for him so he eats it when he comes back. The LPN further indicated he usually gets back on the evening shift around 5:30 p.m.</p> <p>The record for Resident #97 was reviewed on 7/9/14 at 9:20 a.m. The resident was admitted to facility on 5/27/14. The resident's diagnoses included, but were not limited to, renal dialysis, diabetes, contracture, blindness, impairment one eye, below the knee amputation of the left leg, polyneuropathy, muscle weakness, congestive heart failure, and end stage renal disease.</p> <p>Review of the Minimum Data Set (MDS) Admission Assessment dated 6/3/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident needed extensive assist with two person physical assist for transfers. He was limited assist with one person physical assist for bed mobility and</p>			

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	<p>needed physical help with one person assist for bathing.</p> <p>Review of the current plan of care dated 6/8/14, indicated the resident required a therapeutic diet related to his medical diagnoses. The Nursing approaches were the resident will adhere to therapeutic diet through next review. Diet as ordered, encourage oral intake of food and fluids, and monitor weight.</p> <p>Review of the resident's weights indicated he weighed 142 pounds on 5/28/14, 147 on 6/4/14, 149 on 6/10/14, 149 on 6/13/14, 149 on 6/18/14 and 141 on 7/8/14.</p> <p>Review of Physician Orders on the current 7/2014 recap, indicated the resident's diet was a no concentrated sweet, no added salt, no ham, or bacon, no sausage, no tomato, no baked potato, no orange products, and no bananas. A half cup of milk per day and double protein at breakfast daily.</p> <p>Review of the food consumption logs indicated the resident's meal were only monitored on 6/5 for breakfast and dinner, 6/10 for breakfast, and 6/25/14 for dinner. There was no documentation to indicate the resident received a noon meal everyday. There was no</p>			

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	<p>documentation to indicate if he received his lunch before he went to dialysis.</p> <p>Review of Nursing Progress Notes dated 6/1-7/9/14, indicated there was no evidence of any documentation to indicate the resident refused his meals.</p> <p>Interview with the Dietary Food Manager on 7/9/14 at 10:00 a.m., indicated she sends a food tray to the resident before he leaves on dialysis days.</p> <p>Continued interview with the Dietary Food Manager on 7/10/14 at 1:10 p.m., indicated she did not deliver the resident's room tray today. She further indicated she does deliver the resident's lunch tray before dialysis, however, today she did not. She also indicated it was the responsibility of the cook on Saturday to deliver the tray, however, she does not know for sure if the resident gets his lunch tray before dialysis on Saturdays.</p> <p>Interview with LPN #3 on 7/9/14 at 10:15 a.m., indicated the resident will sometime tell us to hold his lunch until he comes back.</p> <p>Interview with the Assistant Director of Nursing on 7/10/14 at 1:55 p.m., indicated it was the resident's choice to have a hot lunch and not a cold lunch</p>			

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	<p>before he left for dialysis.</p> <p>Interview with the Director of Nursing on 7/10/14 at 2:00 p.m., indicated the LPN should have called dietary and sent some kind of lunch with the resident or got him a tray to go.</p> <p>3. On 7/9/14 at 12:50 p.m. Resident #56 was observed lying in bed. He had just been served his lunch tray. He was served ground meat, potatoes, green beans, brownie, and a carton of skim milk. There was no magic cup (a nutritional supplement) observed on his tray.</p> <p>On 7/10/14 at 9:00 a.m., the resident was observed in bed eating breakfast. At that time, he was served a piece of raisin toast, egg casserole, thickened juice and water as well as a bowl of oatmeal. There was no skim milk, nor a magic cup observed on his tray.</p> <p>On 7/10/14 at 12:40 p.m., the resident was observed in bed. He was served his lunch tray. He received ground meat, creamed corn, mashed potatoes, and two cookies. The resident had a red thickened juice and thickened water. The resident did not receive a carton of skim milk nor a magic cup with his lunch.</p>			

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	<p>The record for Resident #56 was reviewed on 7/9/14 at 11:25 a.m. The resident was admitted to the facility on 5/30/14. The resident's diagnoses included, but were not limited to, vascular dementia, dysphagia, and behavioral disturbances with dementia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 6/6/14 indicated the resident was moderately impaired for decision making, and had no delirium or mood issues. The resident needed extensive assist with two person assist with bed mobility and transfers. The resident needed supervision and one person assist with eating.</p> <p>Review of Physician Orders dated 7/7/14, indicated a skilled speech therapy diet order, mechanical soft diet no added salt, skim milk, low cholesterol egg, no liver, no sausage, no bacon, with nectar thick liquids, magic cup with all meals.</p> <p>Interview with LPN #3 on 7/9/14 at 1:40 p.m., indicated she received the order for the magic cup supplement on 7/7/14.</p> <p>Review of the current weights for the resident indicated on 6/18 he weighed 161 pounds, on 6/25/14 he weighed 155 pounds, on 7/2 he weighed 143 pounds and on 7/4/14 he weighed 144 pounds.</p>			

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	<p>Review of the Registered Dietitian (RD) Progress Note dated 7/9/14, indicated the resident had a 11.1% weight loss times one month. The weight loss was suspected due to hospitalization, decreased meal intake, and refusal of care. Health shakes three times a day discontinue, magic cup started with all meals. Recommend 60 cubic centimeters (cc) house supplement three times a day. Will continue to monitor.</p> <p>Review of the current plan of care dated 7/2014, indicated there was no care plan for the resident's weight loss and nutritional approaches.</p> <p>Review of the food consumption log indicated the resident's meals were only recorded on 6/4 dinner, 6/5 breakfast and dinner, 6/9 breakfast, 6/16 dinner, and on 6/25/14 dinner. The resident's intakes were noted as not taken on 6/4, 1-25% for both meals on 6/5, none for 6/9, 51-75% on 6/16, and 1-25% on 6/25/14.</p> <p>Interview with the Director of Nursing on 7/10/14 at 2:50 p.m., indicated the resident should have received his magic cup supplement and the CNAs were to be charting meal consumption in the point of care tracker.</p>			

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F000329 SS=D	<p>3.1-46(a)(1) 3.1-46(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medications related to lack of indication for use and no attempts for a gradual dose reduction two times in the first year for an antidepressant medication and the facility failed to ensure adequate monitoring for pain medication administration for 3 of 5</p>	F000329	<p>F 329</p> <p>PLAN OF CORRECTION</p>	08/13/2014	

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	<p>residents reviewed for unnecessary medications. (Residents #43, #49 and #76)</p> <p>Findings include:</p> <p>1. The record for Resident #49 was reviewed on 7/9/14 at 3:20 p.m. The resident's diagnoses included, but were not limited to, situational depression.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment dated 6/5/14 indicated the resident's Brief Interview for Mental Status (BIMS) was an 8, indicating the resident was alert and oriented with some mild impairment. The resident's depression score was a zero, indicating the resident had no evidence of depression and answered all the questions with no or never for depression and mood problems. The resident was coded as taking an antidepressant seven days.</p> <p>Review of the updated 6/5/14 plan of care with the original date of 2/17/11, indicated the resident was receiving an antidepressant medication and had a history of depression. The Nursing approaches were for the pharmacy consultant to review, and evaluate for need for dosage adjustment/reduction.</p>		<p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>R# 49 medication was reviewed by physician and then facility psychiatrist and discontinued. Resident is being monitored for any decline in mood with discontinued medication. Plan of Care was updated.</p> <p>R #43 was reassessed for pain and plan of care updated accordingly. The nursing staff were reeducated on documentation and pain medication administration.</p> <p>R# 76 medications were reviewed by the interdisciplinary team and the plan of care was updated accordingly. The physician was consulted and medication discontinued. Resident is being</p>				

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	<p>Review of Physician Orders dated 4/25/13, indicated to discontinue Remeron (an antidepressant also used for weight gain) 15 milligrams (mg) at night.</p> <p>Continued review of Physician Orders dated 4/25/13 indicated Zoloft (an antidepressant medication) 25 mg daily.</p> <p>Review of a Pharmacy consultation dated 10/23/13, indicated a recommendation to do a Gradual Dose Reduction (GDR) for the Zoloft medication indicating the resident had been receiving since 4/2013. The recommendation was declined by Physician on 11/4/13.</p> <p>Further review of the Pharmacy consultation report indicated the following was checked by the Physician "Continued use is in accordance with the current standard practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW." Review of the bottom of the page indicated a hand written statement by the Assistant Director of Nursing "11/6/13 keep the current dose-Dx. Situational depression."</p> <p>Review of Physician Progress Notes dated 8/18/13 through 7/6/14, indicated</p>		<p>monitored for any decline in mood.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents with anti-depressants & PRN pain meds are at risk for this alleged deficient practice. Residents with PRN orders were reviewed and any unnecessary medications have been discontinued. An audit of all residents on psychotropic meds has been completed and any issues will be addressed promptly.</p> <p>The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>Nurses were re-educated on proper documentation of PRN medications & unnecessary medications on 7/23/14</p>	

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	<p>there was no documentation or information indicating the resident had any kind of situational depression. The Physician Notes indicated the resident was stable, doing well, with no distress.</p> <p>Review of Social Service Progress Notes dated 4/8/14, indicated the resident reported having a good appetite, sleeping well, having energy, and had no symptoms of depression.</p> <p>Review of a Social Service Progress Note dated 6/10/14, indicated the resident stated he had a good appetite, medium energy, slept well nightly with no symptoms of depression. The resident was polite, friendly, with no undesirable behaviors.</p> <p>Review of a Psychosocial Assessment dated 6/12/14, indicated there was no information of an assessment of depression for the resident.</p> <p>Interview with LPN #3 on 7/10/14 at 12:15 p.m., indicated she had not seen the resident get tearful or cry. She indicated he had not displayed those signs.</p> <p>Interview with the Social Service Director on 7/10/14 at 10:00 a.m., indicated the resident had not expressed</p>		<p>Interdisciplinary team & nursing management were re-educated on reduction of psychotropic meds on 7/30/14.</p> <p>A binder was created with residents on psychotropic meds to keep track of when last reduction was attempted. Social Service director along with DON/ADON will review and notify Psych or attending MD when reduction is due.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>DON / Designee will monitor 10 residents 5 days a week for four weeks. Then 10 residents weekly</p>	

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	<p>any signs or symptoms of depression. She indicated he had always appeared to be happy.</p> <p>Interview with the Director of Nursing on 7/10/14 at 10:05 a.m., indicated the resident was receiving the Zoloft medication for Situational Depression. She indicated the Assistant Director of Nursing had called the Physician back in November 2013 to get that diagnosis. She indicated there was no documentation by the Physician to indicate why he put the resident on Zoloft or for the continued usage of the medication.</p> <p>2. The record for Resident #43 was reviewed on 7/10/14 at 2:00 p.m. The resident was admitted to the facility on 5/7/12. The resident's diagnoses included, but were not limited to, osteoarthritis, neuropathy and schizophrenia.</p> <p>The Minimum Data Set (MDS) Annual Assessment dated 5/13/14 indicated the resident had a BIMS (Brief Interview for Mental Status) score of 12, which indicated mild cognitive impairment.</p> <p>A Physician order dated 5/6/14, indicated the resident was to receive Vicoprofen (hydrocodone and ibuprofen, a controlled pain medication) 7.5 milligrams (mg)/</p>		<p>times a week for 4 months.</p> <p>The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	

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	<p>200 mg every 8 hours as needed for joint or shoulder pain.</p> <p>Review of the Medication Administration Record (MAR) for the month of May 2014, indicated no Vicoprofen had been documented as given for the month of May 2014. The prn flow sheet did not have documentation of Vicoprofen being given.</p> <p>The June 2014 MAR, indicated Vicoprofen was given once on 6/22/14 and 6/23/14. The prn flow sheet had Vicoprofen documented as being given on 6/22, 6/23 and 6/24/14.</p> <p>The July 2014 MAR did not have any Vicoprofen documented as given as of 7/10/14. The prn flow sheet did not have any Vicoprofen documented as given.</p> <p>The Controlled Substance Record indicated the resident received Vicoprofen 10 times in May 2014, 35 times in June 2014 and 11 times as of July 10, 2014.</p> <p>Interview with the Director of Nursing (DoN) on 7/10/14 at 2:40 p.m., indicated prn pain medication was to be documented in the MAR and on the flow sheet, then followed up on in 30 minutes to see if it was effective.</p>			

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	<p>The policy Pain Assessment was received from the DoN on 7/14/14 at 8:40 a.m. The policy indicated, "Pain will be assessed and documented at regular intervals. Evaluation of the effectiveness of analgesic medication in relieving pain should be performed consistent with facility protocol." Documentation should include the type of pain relief used, reassessment of the pain and the resident's response to the pain relief use.</p> <p>3. The record for Resident #76 was reviewed on 7/10/14 at 9:32 a.m. The resident's diagnoses included, but were not limited to, hypertension and depression.</p> <p>Review of the Physician's Orders dated 5/5/14, indicated the resident was to receive Lexapro (an antidepressant medication) 10 milligrams (mg) daily for depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 4/5/14 indicated the resident was not alert and oriented. The resident indicated no feelings of being down, depressed, or hopeless. The resident had no behavior problems and was receiving antidepressant medication.</p> <p>Review of the Annual Minimum Data Set</p>			

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	<p>(MDS) Assessment dated 6/13/14 indicated the resident was alert and oriented and cognitively intact. The resident indicated feelings of being down, depressed, or hopeless with a severity score of 1, on a scale of 0-27. The resident had no behavior problems and was receiving antidepressant medication.</p> <p>Review of the Social Service Progress Note dated 2/5/14 indicated Social Services spoke with the resident regarding consent to be seen by the Psychiatrist due to symptoms of depression.</p> <p>Review of the Psychiatric Evaluation Progress Note dated 2/25/14 indicated the resident was evaluated for depression due to repeatedly crying at times. Further review indicated the resident was lying in bed looking at the ceiling and was unable to answer questions about depression. A new order was initiated for Lexapro.</p> <p>Review of Nursing Progress Notes indicated no evidence of documentation indicating depressed behaviors prior to the resident's psychiatric evaluation on 2/25/14.</p> <p>Interview with the Director of Nursing (DoN) on 7/10/14 at 10:45 a.m., indicated nursing staff were to document</p>			

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F000364 SS=E	<p>resident behaviors on Behavior Sheets and submit the sheets to the social worker. She further indicated there was no evidence of documentation of depressed behaviors in the Nursing Progress Notes.</p> <p>Continued interview with the DoN on 7/11/14 at 9:38 a.m., indicated there were no Behavior Sheets indicating the resident displayed depressive behaviors.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview the facility failed to provide residents with food served at proper temperatures for 1 of 2 meals observed. This had the potential to affect 16 residents who were served room trays on the 1st floor. (The breakfast meal)</p> <p>Findings include: On 7/10/14 at 8:40 a.m., the first cart of breakfast room trays arrived on the 1st</p>	F000364	<p>F364</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does</p>	08/13/2014

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	<p>floor unit. The second cart of breakfast room trays arrived at 8:41 a.m. The first room tray was observed being passed at 8:45 a.m.</p> <p>Two CNA's were observed passing the resident room breakfast trays. The last tray was observed being passed at 9:05 a.m. At that time, temperatures were taken from the remaining tray in the cart. The Western Egg Bake was 93 degrees Fahrenheit, the toast was 82 degrees Fahrenheit, and the milk was 59 degrees Fahrenheit.</p> <p>Interview with a Confidential, alert, and oriented resident on 7/10/14 at 9:45 a.m., indicated the resident ate most of his breakfast meals in his room. He further indicated the food was served cold and he usually only drank the coffee.</p> <p>Interview with the Dietary Food Manager on 7/10/14 at 11:50 a.m., indicated the temperature of the eggs, hot cereal, and milk were checked before they left the kitchen. The eggs were 175 degrees Fahrenheit, the hot cereal was 200 degrees Fahrenheit, and the milk was 34 degrees Fahrenheit. She further indicated the breakfast should have been served at the proper temperature.</p> <p>3.1-21(a)(2)</p>		<p>not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:No residents were identified as being adversely affected.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p>	

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			<p>3. The measures put into place and systemic change made to ensure the deficient practice does not reoccur: Dietary staff was In-serviced on 7/11/14 by the Dietary manager on the immediate change of the Food tray line start time, as well as the change in the cart delivery system. Dietary staff was In-serviced by the Dietary manager on 7/24/14 on the proper use of the Hot Pallet System and instructed staff on keeping milk in the cooler for a substantial period of time prior to meal time, to ensure milk is served at the proper temperature.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is:</p> <p>The Dietary Manager / Designee will audit 5 floor room trays temperature five days for four weeks, then 12 floor room trays weekly for 3 months. Dietary Manager / Designee will also audit delivery time of 2 food carts five days for 4 weeks, then the delivery time of 1 food cart five days a week for 3 months. Any issues found will be</p>	

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F000365 SS=D	<p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, and interview, the facility failed to ensure each resident received food in correct form related to thickened liquids for 1 of 3 residents reviewed for nutrition of the 19 residents who met the criteria for nutrition. (Resident #56)</p> <p>Findings include:</p>	F000365	<p>addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p> <p>F 365</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as</p>	08/13/2014	

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	<p>On 7/9/14 at 12:50 p.m., Resident #56 was observed in bed eating lunch by himself. The resident was served ground meat, potatoes, green beans, and a brownie. The resident was served a carton of skim milk. He also was observed to have two glasses of thickened orange juice and water. The resident was then observed drinking the skim milk from the carton with a straw. At that time, the milk was not thickened and there was no other staff in the room with the resident. Continued observation on 7/9/14 at 1:10 p.m., indicated the resident had finished his meal. CNA #5 came into the room to pick up his tray.</p> <p>Interview with CNA #5 at that time, indicated she had heard the speech therapist say it was ok to give the resident thin liquids because he liked them better and does not like the thickened liquids.</p> <p>On 7/10/14 at 9:00 a.m., the resident was observed in bed eating breakfast. At that time, the resident was observed with a plastic cup of unthickened water in which he had been drinking.</p> <p>The record for Resident #56 was reviewed on 7/9/14 at 11:25 a.m. The resident was admitted to the facility on 5/30/14. The resident's diagnoses included, but were not limited to,</p>		<p>the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>Resident # 56 was assessed by DON and had no adverse effects from alleged deficiency. Physician orders and care plan were updated.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents on thickened liquids are at risk for this alleged deficiency. The interdisciplinary team completed an audit and no other residents were affected by</p>	

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	<p>vascular dementia, dysphagia, and behavioral disturbances with dementia.</p> <p>Review of the current Physician Orders dated 7/7/14, indicated an order for a mechanical soft diet with nectar thick liquids.</p> <p>Interview with the Speech Therapist on 7/10/14 at 3:15 p.m., indicated her recommendation was for the resident to receive nectar thick liquids.</p> <p>3.1-35(d)(3)</p>		<p>this alleged deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>Nursing staff were re-educated on 7/23/14 regarding thickened liquids. The Thicken Liquid system was reviewed and revised to include that a list of residents on thickened liquids is to be kept in the "care alert" book and updated as needed.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>The DON/Designee will monitor 3 residents on thickened liquids 5 days a week for four weeks. Then will continue with audits of at least 5 residents a week for 4 months.</p> <p>The audits will be discussed during our monthly Quality Assurance meeting. The Quality Assurance committee will determine if continued auditing is</p>	

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F000368 SS=E	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on observation, record review and interview, the facility failed to ensure meals were served at the posted times for 3 of 3 meals observed. (Breakfast and</p>	F000368	<p>necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	08/13/2014			

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	<p>lunch)</p> <p>Findings include:</p> <p>1. Observation on 7/7/14 at 12:21 p.m., indicated the tray cart was delivered to the Second floor dining room. At that time, 1 LPN and 2 CNA's started to pass the trays. The second cart was delivered at 12:26 p.m.</p> <p>On 7/9/14 at 9:02 a.m., the second cart was delivered to the Second floor dining room. Staff started to pass the room trays for the Second floor at 9:03 a.m.</p> <p>2. Observation of the lunch meal in the Main Dining Room on 7/7/14 at 12:29 p.m., indicated the first tray was passed to a resident.</p> <p>On 7/9/14 at 9:10 a.m., the breakfast room trays were delivered to the first floor.</p> <p>Interview with CNA #5 at that time, indicated the trays were supposed to be brought down around 8:30 a.m.</p> <p>On 7/10/14 at 8:30 a.m., the Dietary Food Manager was observed taking the second floor breakfast trays upstairs on the elevator.</p> <p>Interview with the Dietary Food Manager</p>		<p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:No residents were identified as being adversely affected.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents residing in the facility</p>	

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	<p>at 8:40 a.m., indicated the times posted for the meals was when the tray line started not when the first trays were passed to the residents. She indicated it took about 15 to 20 minutes to prepare the trays for delivery so the residents would receive their meals starting at 8:20 a.m., not 8:00 a.m. as posted.</p> <p>On 7/10/14, the first tray came out of the kitchen to be served for the Main Dining Room at 8:33 a.m. The room trays were brought to the first floor at 8:40 a.m.</p> <p>Review of the posted meal times indicated the Main Dining Room was to be served at 8:00 a.m., and 12:15 p.m. The second floor was to receive their meal trays at 8:15 a.m., and 12:00 p.m., and the room trays were to be delivered to the first floor at 8:35 a.m., and 12:35 p.m.</p> <p>3.1-21(c)</p>		<p>have the potential to be affected. Any concerns will be addressed immediately.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Dietary staff was In-serviced on 7/11/14 by the Dietary manager on the immediate change on the Food tray line start time, as well as the change in the order of the food cart delivery system.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is:</p> <p>Dietary Manager / Designee will audit the start time for the food tray-line 2 meals five days for four weeks and then 1 meal for five days for 3 months. The Dietary Manager / Designee</p>		

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was served	F000371	will audit the delivery of <u>2 food carts delivery time five days for four weeks, then 1 food cart five days a week for 3 months.</u> Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 8/13/14	08/13/2014

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	<p>and stored under sanitary conditions related to dirty food prep tables, sinks and equipment for 1 of 1 kitchens observed. This had the potential to affect 69 of the 70 residents who resided in the facility. (The Main Kitchen)</p> <p>Findings include:</p> <p>During the Brief Kitchen Sanitation Tour, with the Dietary Food Manager, on 7/9/14 at 9:12 a.m., the following was observed:</p> <p>A. There was a white chalky substance lining the hand washing sink.</p> <p>B. There was a moderate amount of food spillage and debris on the floor.</p> <p>C. The outside of the ice maker was covered with a white chalky substance.</p> <p>D. The inside of the ice maker had a white chalky substance.</p> <p>E. The shelf underneath the counter by the sink was rusted and covered with a white chalky substance.</p> <p>F. There was rust underneath the overhead compartment of the servery.</p> <p>G. All the wheels on the food carts and</p>		<p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: All areas cited during "Brief Dietary Sanitation Tour" were addressed immediately. On 7/9/14 the kitchen was deep cleaned, all food cart / wheels were power washed removing all food debris and spillage. The Ice machine and hand washing sink were cleaned / sanitized inside and out of white chalky substance. The gas pipe along the side of the stove was cleaned removing all grease and dirt. Underneath the microwave was cleaned of crumbs. The side of oven was degreased and kitchen floor was cleaned of all spillage and debris. The compartment servery overhead was cleaned. The shelving under the servery was cleaned of dried food and</p>	

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	<p>tables were dirty and soiled with food debris and spillage.</p> <p>H. The shelving under the servery had a moderate amount of dried food and spillage.</p> <p>I. The microwave had a moderate amount of crumbs underneath it.</p> <p>J. The gas pipe on the side of the stove was greasy and dirty.</p> <p>K. The side of the oven was greasy and dirty.</p> <p>L. The oven hood was covered with large amounts of dust and dirt.</p> <p>M. The freezer was dripping water from the ceiling and there was a moderate amount of water on the floor.</p> <p>N. There were two bags of cereal with no open date, and there was also a bag of brownie mix and yellow cake mix with no open date.</p> <p>Interview with the Dietary Manager at the time, indicated all the above items were in need of cleaning.</p> <p>Interview with the Dietary Manager on 7/11/14 at 11:05 a.m., indicated she did</p>		<p>spillage.</p> <p>All undated items were disposed of (1 package of Cereal, 1 package of Brownie mix and 1 package of yellow cake mix). No other food items with missing dated.</p> <p>On 7/15/14 Seco Refrigeration came and made repairs to the freezer, no dripping water noted.</p> <p>Phoenix Industrial Cleaning is schedule on 8/5/14 @ 7:30 pm to clean Oven hood of dust and dirt.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents that reside in this building and eat meals prepared in facilities kitchen are at risk for this alleged deficient practice. No residents were identified as being affected from this alleged deficient practice.</p> <p>3. The measures put into place and a systemic change made to</p>	

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	<p>not have a cleaning schedule. She further indicated the dietary staff were in charge of cleaning their own section and the weekend staff were responsible for deep cleaning of the kitchen.</p> <p>3.1-21(i)(3)</p>		<p>ensure the deficient practice not reoccur: Dietary staff were re-inserviced concerning Kitchen sanitation and areas cited on 7/11/14. A new "Dietary Cleaning Schedule" was implemented and staff were in-serviced regarding this also on 7/11/14.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Dietary Manager will audit cleaning schedules for completion 5 days a week for four weeks and then 3 days a week for 3 months. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed:</p>	

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 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>		8/13/14	
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	<p>Based on observation, record review and interview, the facility failed to ensure insulin vials and tuberculin solution vials were labeled when opened in 1 of 2 medication rooms throughout the facility. (The Second floor Medication room)</p> <p>Findings include:</p> <p>On 7/14/14 at 10:34 a.m., the following was observed in the Second floor Medication room:</p> <p>a. A vial of house stock Aplisol solution (a solution used to complete tuberculosis (TB) testing) was not dated when opened. This had the potential to affect the 28 residents residing on the Second floor.</p> <p>b. A vial of Lantus insulin for Resident #46 was delivered to the facility on 7/8/14. The insulin was not dated when opened.</p> <p>c. A vial of Novolog insulin for Resident #15 was delivered to the facility on 7/10/14. The insulin was not dated when opened.</p> <p>d. A vial of Levemir insulin for Resident #70 was delivered to the facility on 7/8/14. The vial of insulin was not dated when opened.</p>	F000431	<p>F 431</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>None of the open vials had expired. They had recently been delivered. Charge nurse dated them on 7/14/14 with the date pharmacy delivered them.</p>	08/13/2014

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	<p>e. A vial of Levemir insulin for Resident #85 was delivered to the facility on 6/30/14. The vial of insulin was not dated when opened.</p> <p>Interview with LPN #6 at the time, indicated the vials of insulin and the Aplisol should have been dated when opened.</p> <p>Review of the facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" on 7/14/14 at 12:31 p.m., which was provided by the Director of Nursing and identified as current, indicated the following: "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."</p> <p>3.1-25(j)</p>		<p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>Any resident receiving insulin and resident receiving a TB test are at risk for this alleged deficiency.</p> <p>All vials in facility were audited and no further deficiencies were identified on 7/14/14.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>Nurses were reinserviced on the proper labeling of medications on 7/23/14.</p> <p>4. To ensure the deficient practice does not reoccur, the</p>	

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -		monitoring system established is to: DON / Designee will monitor 100% of vials 3 days a week for four weeks. 100% 1 time a week for 6 months. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 8/13/14	

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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an infection control program was maintained related to ensuring cross contamination of a wound did not occur and an alcohol based hand gel was used after glove removal for 1 of 3 residents reviewed for pressure sores of the 5 who met the criteria for pressure sores. The facility also failed to ensure urinals were stored properly on 1 of 2 units throughout the facility, isolation precautions were</p>	F000441	<p>F 441</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or</p>	08/13/2014

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	<p>initiated for 1 of 5 residents reviewed for infection control, proper glove use was maintained during 1 of 1 observations for incontinence care, and the facility failed to ensure 2 of 5 employees hired within the past 120 days received a tuberculin skin test at the time of hire. (Residents #20, #27, #68, #97, the Second floor, CNA#4 and LPN #5)</p> <p>Findings include:</p> <p>1. On 7/11/14 at 9:39 a.m., the Treatment Nurse was preparing to complete the Wound Vacuum dressing change for Resident #27. The resident was identified as being in contact isolation for ESBL (Extended spectrum beta-lactamase) to her Stage 4 (full thickness tissue loss) pressure ulcers. Prior to entering the room, the Treatment Nurse put on a yellow isolation gown and a head covering. Upon entering the room, the Treatment Nurse washed her hands with soap and water and applied a pair of gloves.</p> <p>At this time, the resident was in her bed positioned on top of an incontinence pad. The Treatment Nurse proceeded to position the resident on her right side and her incontinence brief was unfastened. A large dressing was in place to the resident's coccyx and buttock region. At</p>		<p>liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>R #27 & #68 Don assessed both residents with no adverse effects.</p> <p>R #97 was given a new urinal & the urinal in 202 was replaced and stored correctly thereafter.</p> <p>PPD for employees/ LPN#5 and CNA#4 are both current with their PPD</p> <p>The full isolation was set up immediately on 7/14/14 for R#20.</p> <p>2. The corrective action for those residents having the potential to be affected by the</p>	

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	<p>this time, the dressing was removed and the nurse proceeded to clean the pressure ulcers to the left ischium, coccyx, and right ischium with Dakin's solution (a solution used to treat and prevent skin and tissue infections). After cleaning the areas, the nurse inserted a gauze pad into each wound to keep them covered.</p> <p>The nurse then proceeded to remove the gauze packing from the left ischial wound and apply a thin strip of hydrocolloid (a type of dressing) to the wound edges. The wound was left open to air at this time. The nurse proceeded to remove her gloves and apply a new pair of gloves, she did not use an alcohol based hand gel in between glove changes. The gauze was removed to the right ischial wound and hydrocolloid was applied to the wound edges. The wound was left open to air at this time. After applying the hydrocolloid to the right ischial ulcer, the nurse removed her gloves and applied a new pair of gloves. She did not use an alcohol based hand gel in between the glove change. An opsite transparent dressing was applied to the outside edges of the right ischial ulcer, the left ischial ulcer remained opened to air at this time. The nurse proceeded to remove the gauze from the coccyx wound and apply an opsite transparent dressing to the wound edges and surrounding</p>		<p>same deficient practice:</p> <p>R/T R#2 All residents with wounds are at risk for this alleged deficient practice. During survey they were assessed and none showed adverse effects.</p> <p>R/T R#97 All urinals in the building were checked and no further deficiencies were identified.</p> <p>R/T R#68 All residents receiving care where hand washing or hand gel is to be used are at risk for this alleged deficient practice. No other residents under her care were identified to have been affected by this alleged deficient practice.</p> <p>R/T R#20 All residents requiring isolation rooms were audited no further deficiencies were identified.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p>	

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	<p>intact skin. After changing her gloves and using an alcohol based hand gel, the nurse applied new gloves and proceeded to fold over the edge of the incontinence pad and placed a paper towel on top of the pad with cut out sections of opsite dressings. The nurse proceeded to place opsite dressings around the 3 wounds and surrounding skin. The resident's wounds remained open to air at this time. The nurse then proceeded to cut the foam wound vacuum sponges to size. The nurse removed her old gloves and applied a new pair of gloves without using an alcohol based hand gel in between the glove change. The nurse placed the foam sponges inside the plastic of the wrapper and placed them on top of the resident's bed at this time. The nurse then proceed to insert the foam sponges into each wound and cover the areas with opsite prior to turning on the wound vacuum.</p> <p>Interview with the Director of Nursing (DoN) on 7/14/14 at 1:10 p.m., indicated the Treatment Nurse should have at least used hand gel in between each glove change. The DoN also indicated the Wound Care Nurse should have left each wound covered as much as possible to avoid cross contamination.</p> <p>Review of the facility policy titled "Hand washing/Hand Hygiene" on 7/14/14 at</p>		<p>R/T R#27 Tx nurse was re-inserviced regarding hand washing and cross contamination on <u>7/14/14</u></p> <p>R/T R#97 & R#68 Nursing staff were re-inserviced regarding urinal storage & hand washing on 7/23/14.</p> <p>R/T R#20 Nursing staff were re-inserviced on 7/23/14 on proper isolation set up.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>DON / Designee will monitor 3 residents, with urinals, 3 days a week for four weeks. Then 5 residents weekly for 4 months.</p> <p>DON/Designee will monitor TX nurse during 3 TX weekly for 4 weeks. Then 1 treatment weekly for 4 months.</p> <p>DON/Designee will observe 5 staff members while performing care for proper hand washing / use of hand gel weekly times 4</p>	

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	<p>8:40 a.m., which was provided by the DoN and identified as current, indicated the following: "If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: after removing gloves."</p> <p>2. On 7/7/14 at 11:06 a.m., Resident #97 was observed in bed. At that time, there was a urine filled urinal sitting on top of the resident's over bed table. The urinal had no cap on it and was open.</p> <p>On 7/10/14 at 2:15 p.m., there was an empty urinal sitting on top of the resident's bed side table. The urinal had no lid on top of it. The urinal was not contained in a plastic bag. There were two residents who resided in this room.</p> <p>Interview with the Housekeeping Supervisor on 7/10/14 at 2:15 p.m., indicated the urinals were to be placed in the resident's bathroom and in plastic bags.</p> <p>3. On 7/7/14 at 10:34 a.m., in the bathroom of room 202, there was a urinal hanging on the side of the garbage can. There was no lid noted on top of the urinal and it was not contained in a plastic bag.</p> <p>On 7/10/14 at 1:30 p.m., the urinal was again observed hanging on the side of the</p>		<p>weeks then 3 weekly for 4 months.</p> <p>DON /Designee will audit 100% of all new isolation set up ongoing.</p> <p>The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed:</p> <p>8/13/14</p>				

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	<p>garbage can. There was no lid on top of the urinal and it was not contained in a plastic bag. There were two residents who resided in this room.</p> <p>Interview with the Housekeeping Supervisor on 7/10/14 at 2:15 p.m., indicated the urinals were to be placed in the resident's bathroom and in plastic bags.</p> <p>Interview with the Director of Nursing on 7/14/14 at 11:30 a.m., indicated the lids on the urinals should have been closed.</p> <p>4. On 7/14/14 at 4:45 a.m., CNA #2 was observed entering the room for Resident #68. CNA #2 went into the bathroom and washed her hands, put on gloves and took a towel and put soap and water on one end of the towel and just water on the other end of the towel. She left the bathroom and approached the resident. She explained to the resident what she was going to do. The CNA laid the towel on the over bed table and raised the resident's bed to waist level with her gloved hands. She rolled the resident over and started to remove the resident's brief. She cleaned the front of the resident's peri-area (genital area) with the soapy end of the towel and then rinsed her off with the other end of the towel. She then laid the dirty towel on the over bed table and picked up a dry towel and</p>				

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	<p>dried the front of the resident's peri-area. The CNA put the dry towel back on the over bed table. She then rolled the resident to her right side and indicated to the resident "you had an accident." She used the wet soapy end of the towel to remove the bowel movement from the resident's buttocks. She rinsed the resident's buttocks with the wet end of the towel. She placed the dirty towel in a plastic bag, removed the resident's brief and placed it in the trash. The CNA dried the resident with the dry towel and then placed it in the plastic bag with the other dirty towel. The CNA put a gown on the resident, a pillow case on the pillow under the resident's head and pulled the covers up. The CNA then lowered the resident's bed. At this point, the CNA removed her gloves and picked up the dirty linen, walked down the hall, opened the dirty linen room, disposed of the linen and then washed her hands.</p> <p>The Personal Protective Equipment-Using Gloves Policy was provided by the Director of Nursing on 7/14/14 at 8:40 a.m. The purpose was "To guide the use of gloves." The objectives: to prevent the spread of infection, protect wounds from contamination, and protect hands from potential infectious materials and to prevent exposure from blood or body</p>			

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	<p>fluids. The procedure guidelines: wash hands, obtain gloves, open the package, with one hand grasp the glove by the inside of the cuff and insert hand, pick up remaining glove with gloved hand, and insert un-gloved hand. Removing gloves: after remove of gloves wash hands.</p> <p>Interview with the Director of Nursing (DoN) on 7/14/14 at 2:30 p.m., indicated CNA #2 no longer worked at the facility.</p> <p>Interview with CNA #3 on 7/14/14 at 2:40 p.m., indicated when her gloves were soiled during peri care, she would remove her gloves and put on clean gloves.</p> <p>5. Review of employee records on 7/14/14 at 11:00 a.m., indicated CNA #4 was hired on 5/15/14 and LPN #5 was hired on 4/10/14. The personnel files indicated the two employees had not received a TB (Tuberculosis test) at the time of hire.</p> <p>Interview with the Human Resource Director on 7/14/14 at 3:30 p.m., indicated there were no records to indicate CNA #4 and LPN #5 had received a TB test at the time of hire.</p> <p>6. On 7/14/14 at 4:40 a.m., CNA #1 was observed entering Resident #20's room. There was an isolation sign on the</p>			

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	<p>resident's door. There was not an isolation cart outside of the room or a biohazard container inside the room. The CNA put on a pair of gloves, she did not put on a disposable gown, and changed the resident's brief that was wet with urine. The soiled brief was placed in the garbage and taken to the soiled utility room.</p> <p>Interview with the CNA at 4:48 a.m., indicated she did not know the resident was on isolation precautions.</p> <p>Interview with LPN #2 at that time, indicated the resident had ESBL (an antibiotic resistant organism) in the urine and was on contact isolation precautions. She indicated there should be an isolation cart outside of the room and biohazard bins inside the room. She retrieved a biohazard bin from the supply room and placed it in the residents room.</p> <p>The resident's record was reviewed on 7/14/14 at 12:00 p.m. A Physician's order was received on 7/12/14 for contact isolation for ESBL in the urine.</p> <p>The policy Infection Control Protocol for All Nursing Procedures was received from the Director of Nursing on 7/14/14 at 8:40 a.m. The policy indicated, "2. Transmission-Based Precaution will be</p>			

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F000465 SS=E	<p>used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection", and also indicated, "5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious material".</p> <p>3.1-14(t)(1) 3.1-18(j) 3.1-18(l)</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 the resident's environment was clean and in good repair related to urine odors, marred walls, dirty light fixtures, missing floor tile, rusty floor registers, dirty ceiling vents and missing emergency call light strings for 2 of 2 units. (The first and second floors)</p> <p>Findings include:</p> <p>1. On 7/10/14 at 1:30 p.m., the following was observed during the Environmental Tour on the Second Floor:</p>	F000465	<p>F 465</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in</p>	08/13/2014

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	<p>A. In room 212, there was an accumulation of a dried yellow/brown spillage on the base of the Intravenous (IV) pump pole. There was an accumulation of dust on the light fixture in bathroom and there was no string for the emergency call light in the bathroom. There was one resident who resided in this room.</p> <p>B. In room 221, there was an accumulation of dust on the bathroom light fixture. There was also a strong urine odor in the bathroom. There was one resident who resided in this room.</p> <p>C. In room 202, the bathroom door was marred towards the bottom. There was also a strong urine odor in the resident's bathroom. There were two residents who resided in this room.</p> <p>D. In room 218, there was an accumulation of dust on the bathroom light fixture. The ceiling vent in the bathroom was also dusty. There was one resident who resided in this room.</p> <p>E. In room 228, the wall behind the resident's bed was marred and paint chipped. There was also an accumulation of dust on the bathroom light fixture. There was one resident who resided in this room.</p>		<p>response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. On 7/10/14 all the environmental concerns identified during the survey were immediately addressed and / or resolved. The IV Pump pole in 212 was cleaned. The bathroom light fixtures were dusted in rooms 212, 219, 221, (217-218), (227-228), (225-226). Emergency call light strings were replaced in rooms 119, 121, 123 and 212. The bathrooms were deep cleaned and floors scrubbed in rooms 221 and 202. The bathroom door was painted in room 202. The bathroom ceiling vents were cleaned and painted in rooms (217- 218). The marred walls were painted in rooms 202, 219, 224, 228 and 226 (also painted the wall behind the door frame and the closet door). The marred bathroom door, closet door was painted and the widow curtain was replaced with blinds in room 219. The peeling wall behind the resident bed in room 224 was painted. The heater vent was repaired, the bed table was replaced in room 101 and the</p>	

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	<p>F. In room 227, there was an accumulation of dust on the bathroom light fixture. There was one resident who resided in this room.</p> <p>G. In room 226, there was an accumulation of dust on the bathroom light fixture. The wall behind the door frame and the closet door were paint chipped and marred. There was one resident who resided in this room.</p> <p>H. In room 219, the bathroom door was marred. There was dust on the bathroom light fixture above the sink. The window curtains were stained with water. The paint was peeling around the closet door knobs. There were two residents who resided in this room.</p> <p>I. In room 224, the paint on the wall behind the bed was peeling. There was one resident who resided in this room.</p> <p>J. In room 217, the light fixture in the bathroom had an accumulation of dust. The ceiling vent in the bathroom also had an accumulation of dust. There was one resident who resided in this room.</p> <p>K. In room 225, there was dust noted on the bathroom light fixture. There was one resident who resided in this room.</p>		<p>buckled / cracked wall next to the toilet was scraped, patched and painted in room 123. The caulk around the toilet was replaced in room 121. The missing floor tile on the side of the toilet was replaced in room 102. Both ceiling vents in the first floor shower room were cleaned and painted. The first floor shower room floor register was painted and the ceiling tile frames in both showers were replaced on 7/30/14.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents that reside in this building are at risk with this alleged deficient practice. No residents were identified as being adversely affected.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: On 7/14/14 housekeeping and maintenance staff were re-inserviced regarding repairs and proper cleaning of IV pump poles, bathroom light fixtures, urine odors, rusty</p>	

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	<p>2. On 7/10/14 at 2:00 p.m., the following was observed during the Environmental Tour on the First Floor:</p> <p>A. In room 101 the heating vent was broken. There were two residents who resided in this room.</p> <p>B. In room 122 the base of the over bed table was marred and rusty and in need of painting. There were two residents who resided in this room.</p> <p>C. In room 123 the string for the emergency call light in the bathroom was broken off and shortened. The paint on the wall next to the toilet was buckling and cracked. There were two residents who resided in this room.</p> <p>D. In room 119 the emergency call light string was missing in the bathroom. There were two residents who resided in this room.</p> <p>E. In room 121 the caulking around the toilet was yellow and discolored. The ceiling vent in the bathroom was rusty, and the emergency call light string in the bathroom was broken off. There were two residents who resided in this room.</p> <p>F. In room 102 the floor tile was missing</p>		<p>registers, missing emergency call light strings, marred walls, missing floor tile, stained window curtains and dirty ceiling vents. Housekeeping cleaning schedule has been revised and "Housekeeping / Maintenance audit tools" have been implemented. On 7/15/14 all Department Heads were re-inserviced by the Administrator/ Housekeeping Director on what to look for during guardian angel rounds and how use the maintenance request forms. During all staff meeting on 7/23/14 staff were educated on the use of "maintenance request forms" by the Housekeeping Director.</p> <p>F 465</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Housekeeping / Maintenance Director will monitor <u>5</u> rooms daily</p>	

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F000520 SS=G	<p>on the side of the toilet. There were two residents who resided in this room.</p> <p>G. In the First floor Shower room, the floor registers were marred and rusty. The ceiling tile frame was also rusty in both shower stalls. The ceiling vents were dirty and dusty.</p> <p>Interview with the Maintenance supervisor and Housekeeping supervisor on 7/10/14 at 2:10 p.m., indicated all of the above were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality</p>		<p>for 5 days a week for four weeks. Then 5 rooms weekly for 4 months. Any issues found will be addressed immediately.</p> <p>The audits will be discussed during our monthly QA meeting. All issues found will be addressed immediately. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/13/14</p>	

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	<p>assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to identify and implement a plan of action to correct a quality deficiency related to nutrition for 2 of 3 residents reviewed for nutrition of the 19 residents who met the criteria for nutrition and for ensuring nutritional parameters were maintained for 1 of 1 residents reviewed for dialysis. This had the potential to affect the 70 residents who resided in the facility. (Residents #56, #88, and #97)</p> <p>Findings include:</p> <p>The facility failed to ensure acceptable parameters of nutrition were monitored for Residents #56, #88, and #97 related to the lack of monitoring of a significant weight loss which resulted in the resident falling below her recommended body mass index, implementing Registered Dietitian (RD) recommendations,</p>	F000520	<p>F 520</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have</p>	08/13/2014

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	<p>providing supplements and monitoring the consumption of those supplements as well as meal consumption, completing weekly weights, and ensuring a resident received a lunch tray prior to going to dialysis.</p> <p>Interview with MDS Coordinator on 7/10/14 at 12:45 p.m., indicated Resident #88 had been put on NARS (Nutrition At Risk) on 3/6/14 after her initial weight loss. She was taken off NARS on 4/10/14 because she did not have a significant weight loss that month. She indicated the weekly weights recommended by the RD on 5/14/14 had not been implemented. She indicated the CNA's would document how much each resident ate for each meal. They did not document health shakes, double protein or super cereal specifically. NARS relied on Nursing staff to let them know if the resident was eating the supplements provided. She was not aware the resident was not eating her super cereal or health shakes.</p> <p>Interview with the Director of Nursing on 7/10/14 at 2:50 p.m., indicated Resident #56 should have received his magic cup supplement and the CNAs were to be charting meal consumption in the point of care tracker.</p>		<p>been affected by the deficient practice:</p> <p>The c.n.a informed the nurse of needing a health shake and one was provided to resident. The registered dietician spoke with R#88 during survey. Her likes and dislikes were discussed as well as her supplement preferences. R#88 plan of care was reviewed by the interdisciplinary team and revised accordingly. R#88 continues to be monitored by the Nutrition at Risk Committee.</p> <p>The facility staff delivered a "bag lunch" to R 97 at dialysis on 7/10/14. The Dietary manager met with R 97 to review his preference for meals on dialysis days.</p> <p>The c.n.a informed the nurse of needing a magic cup and skim milk. This was provided for R#56. R #56 continues in Nutrition at Risk for monitoring.</p> <p>The Dietary Manager reviewed meal preferences, likes/dislikes with R # 88, 56 & 97 and updated</p>	

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	<p>Interview with the Dietary Food Manager on 7/9/14 at 10:00 a.m., indicated she sends a food tray to Resident #97 before he leaves on dialysis days.</p> <p>Continued interview with the Dietary Food Manager on 7/10/14 at 1:10 p.m., indicated she did not deliver the resident's room tray today. She further indicated she does deliver the resident's lunch tray before dialysis, however, today she did not. She also indicated it was the responsibility of the cook on Saturday to deliver the tray, however, she does not know for sure if the resident gets his lunch tray before dialysis on Saturdays.</p> <p>Interview with the Administrator on 7/14/14 at 12:45 p.m., indicated the Quality Assurance committee met monthly. She indicated nutrition issues were discussed at the meeting. However, an action plan had not been put into place related to ensuring supplements were provided and meal consumption was continuously monitored.</p> <p>3.1-52(b)(2)</p>		<p>accordingly.</p> <p>The QA&A team continues to meet monthly and review residents that trigger at Nutritional Risk.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents at risk nutritionally have the potential of being affected by the alleged practice.</p> <p>The interdisciplinary team audited dietary recommendations for the months of May, June and July and no further alleged deficiencies were identified.</p> <p>All residents on dialysis that are out of the building during meal times are at risk for this alleged deficient practice. Dietary Manager spoke with staff and residents to ensure that their</p>	

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			<p>preference as to either a “bag lunch” “early tray” or a “saved tray” are honored.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Quality Assurance committee will follow the outlined Quality Assurance calendar which includes a variety of high risk areas including nutrition at risk. Any trends or issues will be reviewed by the interdisciplinary Quality Assurance Committee and determined if system changes are required with follow up audit to ensure compliance. On 7/24/14 the Administrator re-educated the Quality</p>		

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F009999			<p>Assurance team on the calendar that will be followed going forward.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to</p> <p>Administrator/designee will audit Quality Assurance Committee calendar of agenda and audits to ensure areas are addressed with appropriate plan developed to improve systems and care. Audits will continue for at minimum four months and results of audit will be reviewed at Quality Assurance Committee. Any areas identified will be immediately addressed and plan will be revised.</p> <p>5. Completion date systemic changes will be completed:</p> <p>8/13/14</p>		

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	<p>3.1-14 PERSONNEL</p> <p>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:</p> <p>(6) Position in the facility and job description.</p> <p>(7) Documentation of orientation to the facility and to the specific job skills.</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment.</p> <p>This State rule was not met as evidenced by :</p> <p>Based on record review and interview, the facility failed to ensure staff personnel records for employees were current and accurate for 9 of 10 employees reviewed related to not completing references checks, job descriptions and completing general and</p>	F009999	<p>F9999</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were identified as being adversely affected.</p> <p>On 7/22/14 all personnel records identified during the survey were addressed immediately.</p> <ul style="list-style-type: none"> · Physical exams completed for Laundry adie#1 and CNA#7 · Job description signed / 	08/13/2014

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	<p>specific orientation. (Dietary Aide #1, CNA #3, CNA #4, LPN #5, Activity Director, Laundry Aide #1, LPN #4, RN #1, and CNA#7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of Dietary Aide #1's personnel record on 7/14/14 at 11:00 a.m., indicated the employee was hired on 4/22/14. The record indicated there had been no reference checks and specific job orientation had not been completed for the employee. Review of CNA #3's personnel record on 7/14/14 at 11:10 a.m., indicated the employee was hired on 4/10/14. The record indicated there had been no job description provided and no general or specific job orientation had been completed for the employee. Review of CNA #4's personnel record on 7/14/14 on 11:20 a.m., indicated the employee was hired on 5/15/14. The record indicated there had been no reference checks and no specific job orientation completed for the employee. Review of LPN #5's personnel record on 7/14/14 at 11:30 a.m., indicated the employee was hired on 4/10/14. The record indicated there had been no 		<p>completed for Laundry aide#1, CNA#3</p> <ul style="list-style-type: none"> Reference checks completed for CNA#4, LPN#5, RN#1 General Orientation completed CNA#3 Specific Orientation completed - Dietary Aide#1, CNA#3, CNA#4, LPN#5(hire date 4/10/14), Activity Director, Laundry Aide#1, LPN#5(hire date 12/26/14 noted 2567 – actual hire date12/26/13), RN#1, CNA#7 <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected. An audit was completed on 7/31/14 of staff hired in the last 6 months to ensure personnel records were current and accurate. Any concerns will be addressed immediately.</p> <p>3. The measures put into place</p>	

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	<p>reference checks or specific job orientation completed for the employee.</p> <p>5. Review of the Activity Director's personnel record on 7/14/14 at 11:40 a.m. indicated the employee was hired on 11/4/13. The record indicated there had been no job specific orientation completed for the employee.</p> <p>6. Review of Laundry Aide #1's personnel record on 7/14/14 at 11:50 a.m., indicated the employee was hired on 11/26/13. The record indicated no physical exam, job description and job specific orientation had been completed for the employee.</p> <p>7. Review of LPN #5's personnel record on 7/14/14 at 12:00 p.m., indicated the employee was hired on 12/26/14. The record indicated the employee had no job specific orientation completed for the employee.</p> <p>8. Review of RN #1's personnel record on 7/14/14 at 12:10 p.m., indicated the employee was hired on 10/15/13. The record indicated the employee had no reference checks and job specific orientation had not been completed for the employee.</p> <p>9. Review of CNA #7's personnel record</p>		<p>and a systemic change made to ensure the deficient practice not reoccur: Human Resource Coordinator was re-inserviced by the Administrator on 7/24/14 on the completion of the Personnel File Checklist, reference checks, employee job description, general orientation and specific orientation. The new employee packets were revised to include the personnel file check list form, general orientation checklist for all new employees form and job specific orientation form</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Administrator / Designee will audit new hire personnel files prior to employment. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>	

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	<p>on 7/14/14 at 12:20 p.m., indicated the employee was hired on 10/2/13. The record indicated the employee had no physical exam completed.</p> <p>Interview with the Human Resource Director on 7/14/14 at 2:52 p.m., indicated of the ten employee records reviewed, only one employee had job specific orientation.</p> <p>Interview with the Human Resource Director on 7/14/14 at 3:30 p.m., indicated there was no other information to provide in regards to the missing information in the personnel files.</p> <p>3.1-14(a) 3.1-14(q)(6) 3.1-14(q)(7) 3.1-14(t)</p>		<p>5. Completion date systemic changes will be completed: 8/13/14</p>				