

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2015
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NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00160990.</p> <p>Complaint IN00160990- Substantiated. Federal/State deficiencies related to the allegations are cited at F-157 and F-282</p> <p>Survey dates: January 5,6,7,8,9,12 and 13, 2015</p> <p>Facility number: 000025 Provider number: 155064 AIM number: 100274850</p> <p>Survey team: Maria Pantaleo,RN-TC Rita Mullen,RN Bobette Messman, RN (1/5,1/6,1/7,1/8,1/9,1/13)</p> <p>Census bed type: SNF: 8 SNF/NF: 40 Total: 48</p> <p>Census payor type: Medicare: 13 Medicaid: 32 Other: 3 Total: 48</p>	F000000		

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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F000157 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on January 22, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>			

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of an elevated blood sugar for 1 of 4 residents reviewed for following physician's orders (Resident #B).</p> <p>Findings include:</p> <p>The clinical record of Resident #B was reviewed on 1/7/15 at 2:00 P.M. Diagnosis included, but were not limited to, left knee sprain, sleep apnea, chronic respiratory failure, obesity, and diabetes. Resident #B was receiving an oral anti-glycemic and was not on insulin.</p> <p>A Physician's order, dated 12/10/14, indicated, "Accucheck [blood sugar testing] BID [twice a day]."</p> <p>A review of the Medication Administration Record and the Treatment Administration Record, dated for the month of December 2014, indicated a blood sugar levels, on 12/10/14 at 5:00 P.M., of 236 mg (milligrams)/dL (deciliter), on 12/12/14 at 5:00 P.M. was 222 mg/dL, 12/13/14 at 5:00 P.M., was 227 mg/dL, 12/14/14 at 7:00 A.M. was 226 mg/dL, 12/14/14 at 5:00 P.M. was</p>	F000157	<p><b>F157 Notification of Changes</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>"Resident B" no longer resides in the facility.</p> <p><b>2) How the facility identified other residents:</b></p>	02/09/2015			

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	<p>224 mg/dL A normal range for an individual with diabetes non-fasting would be 70-130 mg/dL. There was no indication the Physician was notified of these elevated blood sugars.</p> <p>A review of the Nursing notes for the month of December 2014, did not indicated the physician was notified of the elevated blood sugar.</p> <p>During an interview with the Director of Nursing, on 1/9/15 at 10:00 a.m., she indicated she could not find where the elevated blood sugars were called to the Physician.</p> <p>This Federal tag relates to Complaint IN00160990.</p> <p>3.1-5(a)(3)</p>		<p>An audit will be completed of blood sugar records for the last 30 days on all residents receiving blood sugar checks to identify other residents affected, and that MD will be notified as indicated.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>DON/Designee will audit blood sugar results at least 3x/week to ensure blood sugars were completed as ordered and physician notified of abnormal results. Also, licensed staff will be re-educated regarding physician notification of abnormal blood sugar results and following physician orders.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p>		

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F000242 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure that 4 out of 15 residents interviewed about food choices was given their choice of soup as a meal substitute, (Residents # 5, #46, #20, #13) .</p> <p>Findings included:</p> <p>During Stage 1 of resident interviews the following information indicated choices were not given to residents:</p> <p>a.) During an interview with Resident #46, on 1/5/2015 at 2:47 p.m., she</p>	F000242	<p>DON/Designee will be responsible for oversight of these audits.</p> <p>5) <b>Date of compliance:</b> <b>2/9/2015</b></p> <p><b>F242 Self Determination – Right to Make Choices</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility’s desire to comply with the regulations</p>	02/09/2015	

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	<p>indicated she only received two types of soup, tomato and vegetable, and she had asked for different types at different times and was told they did not have any soup. She indicated she has told staff and resident council that soup is not served very often any more, but nothing had been done to get more soup on the menu. She indicated the ombudsman was aware of her concerns and the facility needed to have more food options.</p> <p>b.) During an interview with Resident #5, on 1/6/2015 at 2:32 p.m., he indicated "the facility did not provide food choices."</p> <p>c.) During an interview with Resident #13, on 1/7/2015 at 10:45 p.m., she indicated the facility did not provide food choices for soups and only had vegetable soup and tomato soup, occasionally.</p> <p>d.) During an interview with Resident #20, on 1/6/2015 at 11:37 a.m., she indicated the facility had no variety with foods and the facility needed to have more soup options.</p> <p>A record review, on 1/9/2015 at 3:00 p.m., of the last two weeks of menus for the facility, indicated soup was served twice during the 2 weeks. One week tomato soup was served. The second</p>		<p>and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>A variety of canned soups were purchased.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Residents will be interviewed regarding food preferences to identify other residents affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>An in-service was held to educate staff on honoring resident food choices.</p> <p>An audit will be done on 5 residents per week to ensure staff is honoring their food choices and results will be reviewed.</p>		

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	<p>week vegetable soup was served. 42 meals served in two weeks and soup was served for 2 meals.</p> <p>A record review, on 1/13/2015 at 11:45 a.m., of the Resident council minutes indicated in May of 2014 and September 2014 residents were not being offered options with food service and residents wanted more soup and not tomato soup.</p> <p>A record review, on 1/13/2015 at 1:50 p.m., of the food committee meeting minutes for January 2015, indicated residents requested more options for soups and for soup to be served more often during meals at the facility.</p> <p>During an interview with the Dietary Manager on 1/13 2015 at 2:00 p.m., she indicated if a resident asked for soup and it was not on the menu, the resident would not get any soup unless some tomato soup was leftover in the refrigerator. She indicated if the resident asked for another type of soup, it was not available.</p> <p>During an interview with the Dietary Manager and the Director of Nursing on 1/13/2015 at 2:30 p.m., The Dietary Manager indicated resident's requests for more soups at meals needed to be discussed with the corporate menu</p>		<p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>Dietary Manager/Designee will be responsible for oversight of these audits.</p> <p><b>5) Date of compliance:</b> 2/9/2014</p>				

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F000282 SS=D	<p>planners/ but that they would try to purchase soups for resident meals until corporate menu planners could adjust menus to reflect resident choices.</p> <p>3.1-3(u)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow a physician's order regarding daily blood sugar testing for 1 of 4 residents reviewed for following physician's orders (Resident #B).</p> <p>Findings include:</p> <p>1. a. The clinical record of Resident #B was reviewed on 1/7/15 at 2:00 P.M. Diagnosis included, but were not limited to, left knee sprain, sleep apnea, chronic respiratory failure, obesity, and diabetes.</p> <p>A hospital transfer Medication List, dated 12/1/14, indicated Resident #84 was to have daily blood sugar testing.</p> <p>A review of the Medication Administration Record and the Treatment</p>	F000282	<p><b>F282 Services By Qualified Person</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p>	02/09/2015

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	<p>Administration Record, dated for the month of December 2014, indicated blood sugar testing was not initiated until 12/10/14.</p> <p>1. b. A Physician's order, dated 12/10/14, indicated, "Accucheck [blood sugar testing] BID [twice a day]."</p> <p>A review of the Medication Administration Record and the Treatment Administration Record, dated for the month of December 2014, indicated BID Accucheck testing was initiated on 12/10/14. Accuchecks were not done on 12/11/14 at 7:00 a.m. or at 5:00 p.m. and 12/12/14 at 7:00 a.m.</p> <p>During an interview with the Director of Nursing, on 1/9/15 at 10:00 a.m., she indicated the blood sugar testing was missed.</p> <p>This Federal tag relates to Complaint IN00160990.</p> <p>3.1-35(g)(2)</p>		<p>Resident "B" no longer resides in the facility.</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit will be completed of blood sugar records for the last 30 days on all residents receiving blood sugar checks to identify other residents affected, and that MD will be notified as indicated.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>DON/Designee will audit blood sugar results at least 3x/week to ensure blood sugars were completed as ordered and physician notified of abnormal results. Also, licensed staff will be re-educated regarding physician notification of abnormal blood sugar results and following physician orders.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be</p>		

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure a safe and free from harm environment for 3 of 30 rooms observed for a clean, sanitary, and a home like environment. (Room 206, 208 and 213)</p> <p>Findings include:</p> <p>1. During resident room observations on 1/5/2015, 1/6/2015, and 1/7/2015, the following was observed:</p> <p>a.) Room 206 1/6/2015, at 2:33 p.m., the call light was not working and the toilet roll holder was broken and metal rough</p>	F000323	<p>reviewed in the Quality Assurance meeting monthly for 3 months, then quarterly x 1</p> <p>DON/Designee will be responsible for oversight of these audits.</p> <p><b>5) Date of compliance: 2/9/15</b></p> <p><b>F323 Free of Accident Hazards/Supervision/Devices</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or</p>	02/09/2015	

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	<p>edges were exposed., resident needed assistance for mobility and used the bathroom facilities.</p> <p>b.) Room 208 1/7/2015 at 2:39 p.m., 6 tiles were missing from floor in resident room, resident was ambulatory.</p> <p>c.) Room 213 1/6/2015 at 2:13 p.m., a metal bracing bracket located close to floor on room dividing wall was exposed, both residents utilized walkers and wheelchairs.</p> <p>On 1/8/2015 at 1:48 p.m., during the environmental tour with the Administrator and Maintenance Supervisor, the Administrator indicated he was unaware the resident rooms needed repair.</p> <p>During an interview, on 1/9/2014 at 2:45 p.m., with the Administrator, he indicated the facility had a system in place for all staff to document environmental concerns, but it was not written.</p> <p>3.1-45(a)(1)</p>		<p>executed solely because it is required by the provisions of federal and state law.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>The call light in room 206 was repaired and the toilet paper holder was replaced.</p> <p>Room 208 was added to the maintenance schedule for repair.</p> <p>Room 213 had the metal bracing bracket covered.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Audits of resident rooms were conducted to identify any potentially hazardous conditions. The results of these audits were turned into maintenance for corrective action.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Staff were in-serviced on how to fill out and turn in maintenance request forms.</p>		

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation record review, and interview, the facility failed to ensure that food was labeled, dated and stored in the dry storage area, refrigerator, and the open kitchen area in one of one kitchens in the facility. This deficiency had the potential to affect 48 of 48 residents who eat meals in the facility.</p>	F000371	<p><b>4) How the corrective actions will be monitored:</b></p> <p>The ED /designee will audit at least 3 resident rooms per week for potential hazards.</p> <p>The results of these audits will be reviewed in the Quality Assurance meeting monthly for 3 months, then quarterly x 1</p> <p><b>5) Date of compliance: 2/9/15</b></p> <p><b>F371 Food Storage The facility requests paper compliance for this citation.</b> Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it</p>	02/09/2015

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	<p>Findings include:</p> <p>During the tour of the kitchen on 1/5/2015 at 9:30 a.m., with the Dietary Manager, the following observations were made:</p> <p>1.) The walk in refrigerator was observed to have open and undated items: 4 pitchers of pink lemonade were opened and no date of opening, 1 bottle of root beer soda opened and no date of opening.</p> <p>2.) The dry storage area was observed to have a container of rice crispy cereal and a container of frosted flakes cereal, with lids not secure and no dates on the containers.</p> <p>3.) The open kitchen area was observed to have 1 bottle of soy sauce opened and not dated, and a package of brown sugar opened and not dated.</p> <p>4.) The toaster conveyor was not cleaned and had food debris and toaster crumbs.</p> <p>5.) The air vent over the warming serving cart had debris on the sides of the vent.</p> <p>6.) The hot plate warming machine had old dried food debris on the hinges and the top of the warmer.</p>		<p>is required by the provisions of federal and state law. <b>1) Immediate actions taken for those residents identified:</b> All items identified to have been opened with no date were immediately discarded. The toaster conveyor was cleaned and sanitized. The air vent was cleaned. The hot plate warming machine was cleaned. The food prep table legs were repainted. The dishwasher room appliances were cleaned. The oven warmer was cleaned. The kitchen was added to the maintenance schedule for needed repairs. <b>2) How the facility identified other residents:</b> The kitchen was audited for proper sanitary conditions. <b>3) Measures put into place/ System changes:</b> Dietary staff will be re-educated regarding policy for food storage and sanitation. The kitchen will be audited weekly for proper sanitary conditions <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in the Quality Assurance meeting monthly for 3 months, then quarterly x 1 The Dietary Manager will review the audits on a weekly basis. <b>5) Date of compliance: 2/9/15</b></p>				

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	<p>7.) The food prep table legs were chipped and scratched.</p> <p>8.) The dishwasher room appliances including the dishwasher had rust, calcium, and lime deposits.</p> <p>9.) The ceiling in the dishwasher room was cracked and peeling and there were 6 tiles near the dirty dishes area of the dishwashing room which were cracked and crumbling.</p> <p>10.) The wall above and behind the ice machine was cracked, crumbling and peeling.</p> <p>11.) The oven warmer was dirty, rust was on the sides of warmer and a black covering was on the inside bottom of the oven.</p> <p>During an interview on 1/5/2015 at 10:05 a.m., with the Dietary Manager, she indicated all open food items should have been dated and stored, and the kitchen items should have been cleaned and free of food and debris. The fan area above the serving tray, she indicated was kept closed to prevent the flow of air onto the food, and the maintenance staff cleaned the vents in the kitchen, not the dietary staff.</p>				

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	<p>During the environmental tour on 1/8/2015 at 1:48 p.m., with the Administrator and Maintenance Supervisor, the Administrator indicated he were unaware of the dishwasher room issues and the vent above the serving area in the kitchen.</p> <p>During an interview, on 1/9/2014 at 2:45 p.m., with the Administrator, he indicated the facility has a system in place for all staff to document environmental concerns for the maintenance department, but it is not written.</p> <p>The facility policy for " food storage (perishables)," undated, received from the Dietary Manager on 1/9/2015 at 2:40 p.m., indicated "... B. Refrigerated items are labeled indicating product and date (month, day and year) products were received or used...."</p> <p>The facility policy for " food storage (non-perishables)," undated, received from the Dietary Manager on 1/9/2015 at 2:40 p.m., indicated "... a. All food staples are stored in sealed or tightly covered containers... C. All items are labeled and dated before storing ...."</p> <p>The facility policy for " cleaning stainless steel," undated, received from the</p>			

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F000441 SS=D	<p>Dietary Manager on 1/9/2015 at 2:40 p.m., indicated "... stainless steel equipment will be properly cleaned and polished, at least weekly...."</p> <p>The facility policy for " cleaning ovens," undated, received from the Dietary Manager on 1/9/2015 at 2:40 p.m., indicated "... Ovens will be cleaned appropriately...."</p> <p>The facility policy for "cleaning automatic toaster (conveyor and pop up)," undated, received from the Dietary Manager on 1/9/2015 at 2:40 p.m., indicated "... The toaster will be cleaned and sanitized after each use...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as</p>			

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	<p>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 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on employee record review and interview, the facility failed to ensure new employees were given a second step tuberculin (TB) skin test. This effected 2 of 5 new employees screenings reviewed for pre-employment TB testing. (Hskp #1, Dietary #1)</p> <p>Findings include:</p> <p>During a review of the employee records on 1/12/15 at 4:30 p.m., the following items were not found.</p> <p>1. The second step TB skin test for</p>	F000441	<p><b>F441 Infection Control</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations</p>	02/09/2015	

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	<p>Hskp#1, hired on 10/2/14.</p> <p>2. The second step TB skin test for Dietary #1, hired on 11/29/14.</p> <p>During an interview with the Executive Director on 1/13/15 at 3:30 p.m., he indicated there was no evidence the second step TB skin test had been completed on the employees.</p> <p>3.1-18(k)</p>		<p>and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Hskp #1 is no longer employed by the facility.</p> <p>Dietary #1 had the proper TB skin test completed.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Employee files were audited to ensure that all had 1st and 2nd step tuberculin testing.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>New hire employee files will be audited weekly to ensure that all have received a first and second step tuberculin test. First step tuberculin test will be placed prior to or on hire date, and second step will be placed 7-21 days later if first step results are negative. Any discrepancies will</p>		

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F000463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview the facility failed to provide a functioning call light for 1 of 30 residents observed for the call light function. (Resident # 1)	F000463	be addressed immediately. The Business Office Manager will be responsible for oversight of these audits.  <b>4) How the corrective actions will be monitored:</b>  The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.  BOM/Designee will be responsible for oversight of these audits.  <b>5) Date of compliance:</b> 2/9/2015  <b>F463 Resident Call System</b>	02/09/2015	

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	<p>Findings included:</p> <p>During resident room observations on 1/5/2015, 1/6/2015, and 1/7/2015, the following was observed:</p> <p>Room 206: (Resident #) 1/6/2015 at 2:33 p.m., there was a hole in wall covered by a metal bar with the call light attached, and the call light was not working.</p> <p>On 1/8/2015 at 1:48 p.m., during the environmental tour with the Administrator and Maintenance Supervisor, the Maintenance Supervisor indicated he was not unaware the call light was not functioning properly.</p> <p>During an interview, on 1/9/2014 at 2:45 p.m., with the Administrator, he indicated the facility had a system in place for all staff to document environmental safety concerns, but it is not written.</p> <p>3.1-19(u)(1)</p>		<p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>The call light in room 206 was replaced and is functional.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All call lights in facility were checked for proper function.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Staff were in-serviced on the</p>		

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F000465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 38 of 38 resident entry doors and bathroom	F000465	<p>maintenance request forms.</p> <p>An audit will be done in 3 rooms per week for call light function.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>ED/Designee will be responsible for oversight of these audits.</p> <p><b>5) Date of compliance:</b> 2/9/2015</p>	02/09/2015			

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	<p>doors, 11 of 30 resident rooms ( walls, floors, closets and furniture), ( Room's #, 101, 102, 110, 117, 206, 207, 208, 209, 213, 300, and 302) and 4 of 30 rooms without light pull cord attachments ( Rooms#, 101, 109, 206, and 302). This deficient practice had the potential to impact 48 residents out of 48 residents utilizing rooms in the facility.</p> <p>Findings include;</p> <p>1. During the initial tour on 1/5/2015 at 10:30 a.m., the following was observed:</p> <p>a.) All resident rooms 38 out of 38 resident entry door and bathroom doors were observed to be chipped , marred, scratched and peeling.</p> <p>b.) Resident dining room furniture, tables and chairs were chipped, marred, and scratched.</p> <p>2. During resident room observations on 1/5/2015, 1/6/2015, and 1/7/2015, the following was observed:</p> <p>a.) Room 110: 1/7/2015 at 1:12 p.m., the dresser was chipped, peeling, marred, and scratched and the closet door was marred and would not close.</p> <p>b.) Room 117: 1/7/2015 at 10:43 a.m.,</p>		<p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>1. Initial Tour</p> <p style="padding-left: 40px;">A. All room doors have been added to a schedule for repair.</p> <p style="padding-left: 40px;">B. All dining room tables have been added to a schedule for repair.</p> <p>2. Resident Room Observations</p> <p>A. Room 110 - This dresser was a personal dresser of a resident and has been removed from facility. The closet door was repaired.</p>				

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	<p>the room walls were chipped, peeling, marred, and scratched.</p> <p>c.) Room 206: 1/6/2015 at 2:33 p.m., the room walls were chipped, peeling, marred, cracked and scratched. There was a hole in the wall covered by a metal bar with call light attached, call light was not working and a toilet roll holder was broken and metal rough edges were exposed .</p> <p>d.) Room 207: 1/5/2015 at 4:08 p.m., the room walls were chipped, peeling, marred, and scratched.</p> <p>e.) Room 208: 1/7/2015 at 2:39 p.m., the room walls were chipped, peeling, marred, and scratched. The closet door was chipped and marred, the sink faucet did not turn completely off, and 6 tiles were missing from the floor in resident room.</p> <p>f.) Room 209: 1/7/2015 at 11:16 a.m., the room walls were chipped, peeling, marred, and scratched.</p> <p>g.) Room 213: 1/6/2015 at 2:13 p.m., the room walls were chipped, peeling, marred, and scratched. A metal bracing bracket located close to floor on room dividing wall was exposed.</p>		<p>B. Room 117 has been added to the schedule for repair.</p> <p>C. Room 206 has been added to the schedule for repair. The call light cover was replaced and the call light was repaired. The toilet roll holder was replaced.</p> <p>D. Room 207 has been added to the schedule for repair.</p> <p>E. Room 208 has been added to the schedule for repair.</p> <p>F. Room 209 has been added to the schedule for repair.</p> <p>G. Room 213 has been added to the schedule for repair. The metal bracing bracket was covered.</p> <p>H. Room 300 has been added to the schedule for repair.</p> <p>I. Room 302 has been added to the schedule for repair.</p> <p>3. Environmental Tour</p> <p>A. Room 101 – the light switch was replaced and the room has been added to the schedule for repair.</p> <p>B. Room 102 – the light switch was replaced and the room has been added to the schedule for repair</p> <p>C. All resident rooms had</p>				

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	<p>h.) Room 300: 1/7/2014 at 2:02 p.m., the room walls were chipped, peeling, marred, and scratched and the wallpaper was ripped.</p> <p>i.) Room 302: 1/6/2015 at 11:50 a.m., the room walls were chipped, peeling, marred, and scratched.</p> <p>3. During the environmental tour on 1/8/2015 at 1:48 p.m., with the Administrator and Maintenance Supervisor, the following was observed:</p> <p>a.) Room 101: the light switch plate was rusted and the wallpaper was ripped .</p> <p>b.) Room 102: the light switch plate was rusted and there was a hole in the plaster on the bathroom wall.</p> <p>c.) Rooms 101, 109, 206, and 302 were missing attachment for the utilization of room overbed lights.</p> <p>During the environmental tour on 1/8/2015 at 1:48 p.m., with the Administrator and Maintenance Supervisor, the Administrator indicated he was unaware the resident rooms needed repair. He indicated he was aware the resident entry door and bathroom doors were chipped, peeling, marred and scratched, but he indicated there were no</p>		<p>attachments added for utilization of overbed lights.</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit of the facility was completed to identify a clean, sanitary, home like environment.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Staff will be in-serviced on the use of Maintenance Request forms.</p> <p>An audit will be done on environmental needs 3 times a week and results will be reviewed in clinical morning meeting.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3</p>		

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F000497 SS=D	<p>plans to fix these rooms.</p> <p>During an interview, on 1/9/2014 at 2:45 p.m., with the Administrator, he indicated the facility had a system in place for all staff to document environmental concerns, but it is not written.</p> <p>3.1-19(f)</p> <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>Based on employee record review and interview, the facility failed to ensure new and current employees were inserviced regarding resident rights for 2 of 10 employee files reviewed. (CNA#1 and QMA#1)</p> <p>Findings include:</p> <p>During a review of the employee files on</p>	F000497	<p>months and quarterly x1 for a total of 6 months.</p> <p><b>F497 Nurse aide perform review</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an</p>	02/09/2015			

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	<p>1/12/15 at 4:30 p.m. the following items were not found:</p> <p>1. The employee file for CNA#1 employed since 10/13/11 was reviewed, no current training on Resident Rights, Dementia, and Abuse were found.</p> <p>2. The employee file for QMA#1 employed 11/10/14 was reviewed, no training on employment was found on Resident Rights, Dementia, and Abuse.</p> <p>During an interview with the Executive Director on 1/13/15 at 3:30 p.m., he indicated he had no evidence of training for the identified individuals. He indicated all employees are required to have training on employment and annually thereafter.</p> <p>3.1-14(k)(1)(5) 3.1-14(k)(6) 3.1-14(l)</p>		<p>admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>CNA #1 and QMA #1 each were in-serviced on Abuse, Dementia, and Resident Rights.</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit of all employee files was performed to ensure training was completed for abuse, dementia and resident rights.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>New employee files will be audited weekly to ensure training was completed prior to working on the floor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2015
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			<p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.</p> <p>BOM/Designee will be responsible for oversight of these audits.</p> <p><b>5) Date of compliance:</b> 2/9/2015</p>		