

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: May 8, 9, 12, 13 & 14, 2014</p> <p>Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310</p> <p>Survey Team: Shauna Carlson, RN - TC Julie Baumgartner, RN Sharon Ewing, RN Pamela Williams, RN</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type: Medicare: 8 Medicaid: 70 Other: 20 Total: 98</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 22, 2014, by Brenda Meredith, R.N.</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>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 related to a residents non-compliance with a physician ordered treatment for 1 of 4 residents reviewed. (Resident #50)</p> <p>Findings include:</p> <p>On 5-8-2014 at 3:25 P.M., interview with LPN (Licensed Practical Nurse) #3 indicated "...he [Resident #50] removes his collar all the time...."</p> <p>On 5-8-2014 at 3:30 P.M., record review of Resident #50 indicated an admission date of 10-30-2013. A Physician order, dated 10-30-2013, indicated "Miami J Collar [cervical collar] every shift related to AFTERCARE FOR HEALING PATHOLOGIC FRACTURE."</p> <p>On 5-12-2014 at 10:10 A.M., record review of the following nurses notes indicated that Resident #50 is frequently non-compliant with the ordered treatment to wear the Miami J collar (cervical collar) at all times:</p> <p>5-10-2014 at 4:23 A.M., "...resident said he did not want it while in bed...."</p>	F000157	<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>It is the practice of this facility to notify the physician related to a residents non-compliance with a physician ordered treatment. Consistent with this practice, the following actions have been taken:</p> <p>I. A review of resident #50's medical record was conducted and all necessary notifications were made.</p> <p>II. All residents' have the potential to be affected, therefore all residents' medical records were reviewed from previous 30 days to ensure that necessary notifications were made</p> <p>III. Licensed nursing personnel shall be in-serviced on Golden Living (GL) guideline regarding Notification of Change in Resident Health Status. A QAPI tool has been developed to monitor ongoing compliance titled, "F-157 Family & Physician Notification" that the DNS or designee will utilize to monitor daily, on scheduled days of</p>	06/13/2014			

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	<p>2-7-2014 at 8 P.M., "...Neck brace in place but resident continues to take it off. Nursing staff re-applied [sic] and resident encouraged not to take it off but resident was noted ambulating on the hall way with neck brace off...."</p> <p>2-6-2014 at 11:18 P.M., "...Removes neck brace continually on writers shift. Educated resident on the importance of keeping neck brace on...."</p> <p>2-6-2014 at 3:36 P.M., "...Neck brace in place but resident continues to take it off. Nursing staff re-applied [sic] and resident encouraged not to take it off...."</p> <p>2-2-2014 at 3:58 P.M., "...resident has order for Miami J Collar of which resident keep on taking it off several times this shift, Miami J Collar was re-applied and resident was educated the importance of it...."</p> <p>1-27-2014 at 10:43 P.M., "...Resident continues to remove J collar. Educated resident on the importance of wearing neck brace...."</p> <p>1-23-2014 at 11:15 P.M., "...Resident continues to remove J collar on writers shift...."</p> <p>Resident #50's care plans indicated</p>		<p>work, times 4 weeks, that necessary notification are made timely, in accordance with the Federal guidelines.</p> <p>IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p> <p>Date of Compliance: 06.13.14</p>	

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	<p>"Focus...I also have a history of being non-compliant with care...Interventions...Let my physician know if my behaviors are interfering with my daily living...."</p> <p>On 5-14-2014 at 9:15 A.M., interview with DCE (Director of Clinical Education) indicated "...the physician was not notified of the residents non-compliance...."</p> <p>On 5-14-2014 at 12:20 P.M., review of Notification of Change in Resident Health Status policy, received from the Social Worker as current policy, indicated, "...The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is:.. (C) A need to alter treatment significantly...Criteria: A need to alter treatment 'significantly' means...commence a new form of treatment to deal with a problem...Notification: Depending on the nursing assessment appropriate notification may be immediate to 48 hours...."</p> <p>3.1-5(a)(3)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by</p>			
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	<p>the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to initiate a care plan for a Miami J collar (cervical collar) for 1 of 1 resident reviewed. (Resident #50)</p> <p>Findings include:</p> <p>On 5-8-2014 at 3:20 P.M., observation of CNA (Certified Nurses Aide) #2 adjusting Resident #50's Miami J collar by placing one hand on the front of the collar and one hand on the back of the collar and twisting counter-clockwise to straighten it.</p> <p>On 5-8-2014 at 3:25 P.M., interview with LPN (Licensed Practical Nurse) #3 indicated "...nurses are the only ones allowed to adjust the collar...." Interview at this time with CNA #2 indicated "...I turned the collar to straighten it up...."</p> <p>On 5-8-2014 at 3:30 P.M., record review of Resident #50 indicated an admission date of 10-30-2013. A Physician order, dated 10-30-2013, "Miami J Collar every shift related to AFTERCARE FOR HEALING PATHOLOGIC FRACTURE." An assessment on the History and Physical from [local</p>	F000272	<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>It is the practice of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. More specifically, it is the practice of this facility to initiate a plan of care for residents with Miami J collars (cervical collars). Consistent with this practice, the following actions have been taken:</p> <p>I. Resident # 50's care plan was updated to include requirement of licensed nursing personnel for applying, re-positioning, withdrawing, and assessment of the Miami J collar. Care plan updated to include procedures and guidelines for Cervical Collar and C6 fracture care. Also updated on the care plan of resident #50 was his non-compliance with care and expectation to make necessary</p>	06/13/2014

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F000282 SS=D	<p>hospital], dated 10-18-2013, by [local doctors name], indicated "...Assessment and Plan:...13. C6 fracture...Dr. [local doctor's name-neurosurgeon] has evaluated and is recommending a Miami J collar...." There were no care plans related to C6 fracture or Miami J collar noted in the record.</p> <p>On 5-14-2014 at 11:00 A.M., interview with the DCE (Director of Clinical Education) indicated "...there is no care plan related to the C6 fracture or Miami J collar...the CNA care sheet did not indicate the need to contact the nurse to for care related to the Miami J collar...."</p> <p>3.1-31(e)</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</p>		<p>notifications.</p> <p>II. All residents' care plans shall be reviewed and updated as necessary to ensure that they are accurate and comprehensive; meeting the current needs of each resident individually.</p> <p>III. Nursing personnel and the Interdisciplinary team (IDT) will be in-serviced on the resident assessment and care planning policy to ensure accuracy, timeliness, and ongoing implantation. A QAPI tool was developed titled, "F-272 Comprehensive Assessments" that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that the assessments and care plans are accurate & timely, in accordance with the Federal guidelines as defined in RAI Manual. The tool will monitor that assessments are utilized to develop comprehensive care plans to meet the individualized needs of all residents needs and interests.</p> <p>IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p>		

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	<p>persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper placement of resident safety alarm on wheelchair for 1 of 1 residents observed. (Resident #118)</p> <p>Findings include:</p> <p>On 5/13/14 at 1:45 P.M., an observation of resident #118 indicated he was sitting on a sensory mat but alarm box was not present on wheelchair.</p> <p>During an interview on 5/13/14 at 2:00 P.M., LPN #4 indicated the nurses are to check alarm placement and function every shift. LPN #4 further indicated that CNAs monitor for placement throughout day when working with resident, if there is a problem with alarm CNA should notify the nurse.</p> <p>During an interview on 5/13/14 at 2:21 P.M., CNA #5 indicated that she checks the resident and alarm every 15 minutes. If there is a problem with the alarm she gets a new alarm and places it if resident needs one. CNA #5 further indicated she gets resident information "...via daily care assignment sheet, but [name of resident #118] does not have a alarm listed on sheet for today...."</p>	F000282	<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>It is the practice of this facility to provide or arrange qualified persons in accordance with each resident's written plan of care. Consistent with this practice, the following actions have been taken:</p> <p>I. The alarm of resident # 118 was observed and resident was provided with a functioning alarm. Resident # 118's assessment, CNA care guide, and care plan were updated to ensure that each reflected accurate information regarding resident's care needs.</p> <p>II. All residents' with alarms were observed to ensure that alarms were in place and functioning properly. All residents' assessments, care plans, and CNA care guides were reviewed and updated as necessary.</p> <p>III. Nursing personnel and IDT will be re-educated on facility's protocol related to monitoring, communication, and documentation of alarm function. A QAPI tool has been developed to monitor ongoing compliance titled, "F-282 Alarm Placement & Function" that the DNS or designee will utilize to</p>	06/13/2014			

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F000323 SS=D	<p>During an interview on 5/13/14 at 2:23 P.M., RN #6 indicated nurses are required to check function and placement of the alarm each shift. CNAs are notified of new treatments/ orders per their daily assessment sheet. New treatments/orders are placed in bold on care assignment sheets. Residents that have alarms CNA's should check that alarms are in place and functioning throughout the day while working with the resident.</p> <p>On 5/14/14 at 9:15 A.M., a review of fall care plan, last updated 4/21/14 "...interventions...sensor alarms to bed and w/c (wheel chair)...."</p> <p>3.1-35(g)(1)</p> <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. 1. Based on observation, interview and record review, the facility failed to ensure staff were properly trained on an assistive</p>	F000323	<p>monitor daily, on scheduled days of work, times 4 weeks, that proper placement of alarms is found in accordance with the Federal guidelines. IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or</p>	06/13/2014			

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	<p>device that promotes safety for 1 of 1 resident observed with a Miami J collar. (Resident #50)</p> <p>2. Based on observation, interview and record review, facility failed to ensure a safe environment related to hot water temperatures for 3 of 3 rooms sampled.</p> <p>Findings include:</p> <p>1. On 5-8-2014 at 3:20 P.M., observation of CNA (Certified Nurses Aide) #2 adjusting Resident #50's Miami J collar by placing one hand on the front of the collar and one hand on the back of the collar and twisting counter-clockwise to straighten it.</p> <p>On 5-8-2014 at 3:25 P.M., interview with LPN (Licensed Practical Nurse) #3 indicated "...nurses are the only ones allowed to adjust the collar...." Interview at this time with CNA #2 indicated "...I turned the collar to straighten it up...."</p> <p>On 5-8-2014 at 3:30 P.M., record review of Resident #50 indicated an admission date of 10-30-2013. A Physician order, dated 10-30-2013, "Miami J Collar every shift related to AFTERCARE FOR HEALING PATHOLOGIC FRACTURE." An assessment on History and Physical from (local hospital), dated</p>		<p>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. It is the practice of this facility to ensure that staff is properly trained on assistive devices that promotes safety for residents. It is also the practice of this facility to ensure a safe environment related to hot water temperatures for all residents. Consistent with this practice, the following actions have been taken: 1. 1. Resident #50 no longer has physician order for the Miami J collar. The resident's assessment, plan of care, and CNA care guide was updated to reflect the new physician orders and plan of care. Caregivers were provided education specific to his needs at that time related to the new assistive device. 2. Water temperature was reduced at the boiler immediately. The residents in rooms identified in survey as 202, 223, and 232 were assessed and no injuries were noted. These rooms, in addition to all other resident accessible water access points were monitored by assigned staff until 100% of the water temperatures could be re-taken and found within a complaint range. The temperatures were taken using the tip of the thermometer rather</p>				

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	<p>10-18-2013, by (local doctors name), indicated "...Assessment and Plan:...13. C6 fracture...Dr. [local doctor's name-neurosurgeon] has evaluated and is recommending a Miami J collar...."</p> <p>On 5-13-2014 at 11:43 A.M., observation of ADON (Assistant Director of Nursing) adjusting Resident #50's Miami J collar by grasping the front of the collar and the back of the collar and twisting counter-clockwise to straighten it. The resident was sitting in his wheelchair in the assisted dining room on B-wing.</p> <p>On 5-14-2014 at 9:15 A.M., interview with the DCE (Director of Clinical Educator) indicated that "...I do education with the staff before a resident with special needs comes into the building...I started in November and he was admitted in October...we do not have a policy related to cervical collars...." Interview with ADON, at this time, indicated "...I do not remember any education given prior to his [Resident #50] admission...."</p> <p>On 5-14-2014 at 9:30 A.M., review of the Nurse Orientation checklist indicated no training area related to cervical collars or spinal precautions.</p> <p>2. On 5/13/14 at 10:48 A.M., an</p>		<p>than the middle of the thermometer. II. All residents' care plans shall be reviewed and updated as necessary to ensure that they are accurate and comprehensive; meeting the current needs of each resident individually. Any assistive devices identified that require additional staff education, this education will be provided to them as necessary. 2. Water temperature was reduced at the boiler immediately. All of the resident-accessible water access points were assigned to be monitored by the staff until 100% of the water temperatures could be re-taken and found within a complaint range. . The temperatures were taken using the tip of the thermometer rather than the middle of the thermometer. III. All licensed nursing personnel and the Interdisciplinary Team will be in-serviced on the federal regulation F-323, specifically the facility's responsibility to ensure that staff is provided education on assistive devices that promote the safety of all residents. A QAPI tool has been developed to monitor ongoing compliance titled, "F-323 New Assistive Device Education" that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that proper training has taken place when new orders are received for assistive devices for residents. 2.</p>	

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	<p>observation of water temperature in Room 202 was 121.6 degrees.</p> <p>On 5/13/14 at 10:50 A.M., an observation of water temperature in Room 223 was 122.2 degrees.</p> <p>On 5/13/14 at 10:53 A.M., an observation of water temperature in Room 232 was 121.1 degrees.</p> <p>On 5/13/14 at 11:00 A.M., an interview with the maintenance director indicated that he never has calibrated the thermometer that he uses for temping the water. He further indicated when he temps the water he places the middle of the probe under the running water and not the end of the probe.</p> <p>On 5/14/14 at 12:45 P.M., the Executive Director provided the current policy "Maintaining Water Temperature" undated. "...Check state regulations to ensure that water temperatures are within allowable ranges...."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>		<p>The Director of Maintenance and Maintenance Assistance were provided re-education on the facility's protocol for maintaining a safe environment including the monitoring water temperatures, proper temperature taking, and thermometer calibration practices. A QAPI tool has been developed to monitor ongoing compliance titled, "F-323 Water Temp Logs & Observation" that the ED or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that water temperatures are compliant, logs are maintained and by observation that temperatures are obtained accurately. IV. The ED or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p>		

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent (%) for 1 of 4 residents observed during medication pass. Two (2) medication errors were observed during 35 opportunities for error in medication administration. This resulted in a medication error rate of 5.7%.</p> <p>Findings include:</p> <p>On 5/14/14 at 9:01 A.M., Employee #4 was observed preparing to administer medications to Resident #109. Employee #4 was preparing to administer Aspirin 81 mg and Neurontin 300 mg. Upon interview at this time, Employee #4 indicated the resident received her medications by mouth.</p> <p>On 5/14/14 at 9:05 A.M., an observation was made of Resident #109 receiving her medications by mouth.</p> <p>On 5/14/14 at 10:00 A.M., the Electronic Medication Administration Record was</p>	F000332	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. It is the practice of this facility to ensure a medication error rate of less than 5 %. Consistent with this practice, the following actions have been taken: I. Resident #109 was assessed and no adverse affects from the deficient practice were noted. The resident's physician and family were notified of the deficient practice and corrective measures taken. Physician orders were received for resident to receive medications by mouth. Resident # 109's medical record, including but not limited to the care plan and medication administration record (MAR) to ensure complaint medication administration. II. The physician orders and (MARs) of all residents will be audited to ensure compliance with GL	06/13/2014			

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	<p>reviewed. The Electronic Medication Administration Record indicated the following physicians orders: "... Aspirin Tablet 81 mg [milligrams] Enteral Tube Once daily...Neurontin (300 mg) (Gabapentin) Capsule 300 MG Enteral Tube Three times a day 300 mg Capsule Enteral Tube Give 300 MG three times per day...." The physicians orders were signed, on 5/13/14, by the residents attending physician.</p> <p>On 5/14/14 at 10:15 A.M., the clinical record for Resident #109 was reviewed. The Patient Transfer Assessment Form (from a local hospital), dated 10/19/12, indicated the following: "...Nurse Discharge Summary/Current Problem: Failed swallow study, NPO, Peg tube placed, tolerating continuous feedings well...."</p> <p>On 5/14/14 at 10:30 A.M., an interview with the Assistant Director of Nursing was conducted. The Assistant Director of Nursing indicated the resident at one time had a g-tube. She further indicated she thought the g-tube was removed the end of May 2013. She indicated "...the orders did not get changed over..." from enteral route to oral route.</p> <p>On 5/14/14 at 1:20 P.M., Patient Discharge Instructions from (Name of</p>		<p>guideline for medication administration as well as federal regulation. III. Licensed nursing personnel will be in-serviced on GL Guideline Medication Administration - Preparation & General Guidelines and Medication Review - Admission / Re-Admission Guideline. ADNS and clinical leadership team will be in-serviced on Monthly Medication Reconciliation Guideline to ensure compliance with federal regulation F-332. A QAPI tool has been developed to monitor ongoing compliance titled, "F-332 Medication Error Prevention." The tool will be utilized by the DNS and IDT during the daily clinical meeting to review all new orders to ensure compliance with Medication Administration Guideline and Admission / Re-Admission Guideline. Included on the QAPI tool titled, "F-332 Medication Error Prevention" is a review of the tool titled, "F- 332 Medication Administration Competency Observation". The DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that medications are administered as ordered and if errors occur they are less than 5%. IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of less than 5%</p>				

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F000371 SS=E	<p>local hospital) dated 5/28/13 indicated the following physician orders: "... Aspirin 81 mg, by mouth, once a day...Gabapentin 300 mg, by mouth, 3 times per day...."</p> <p>On 5/14/14 at 1:30 P.M., the Social Service Director provided a policy titled Medication Administration - General Guidelines. Review of the policy at this time indicated "...4. Five Rights-Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered...."</p> <p>3.1-25(b)(9)</p> <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 1. Based on observation, interview and record review, the facility failed to ensure</p>	F000371	<p>error rate is consistently maintained. The Consultant Pharmacist will review the completed QAPI tool titled, "F-332 Medication Error Prevention" findings monthly times 6 months to determine need for continued monitoring thereafter until a threshold of less than 5% medication error rate is consistently maintained.</p> <p>Preparation and/or execution of this plan of correction does not</p>	06/13/2014

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	<p>proper storage, preparation and distribution of food under sanitary conditions in the kitchen. In 1 of 1 kitchens.</p> <p>2. Based on observation, interview and record review, the facility failed to ensure residents were served food under sanitary conditions related to handwashing and infection control practices. These deficient practices have the potential to affect all residents who eat their meals in 3 of the 4 dining rooms at the facility.</p> <p>Findings include:</p> <p>1. On 5/8/14 between 10:35 A.M. and 11:30 A.M., during initial kitchen tour, the following was observed:</p> <p>A. The prep table spice rack had open and undated containers of brown sugar, sage, drill weed, red pepper, thyme, cayenne pepper, allspice, cumin seed, rosemary leaves, poultry seasoning, chili powder, lemon pepper, basil, black pepper, granulated onion, garlic, paprika, oregano, sesame seeds, cloves, cinnamon, large container of oregano and large container of parsley.</p> <p>B. Four coffee carafes stored upright on clean shelf with lids off.</p>		<p>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. It is the practice of this facility to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute, and service food under sanitary conditions. Consistent with this practice, the following actions have been taken: 1. The carrots, cinnamon rolls, broccoli, corn, peas, cauliflower, lima beans, brussel sprouts and sweet potato fries in the walk-in freezer were immediately discarded when noted to be undated. All the spices, brown sugar, macaroni, and designer sauce that were noticed to be dated were discarded immediately. The dented can was immediately removed from the store room. The four carafes found upright and without lids were cleaned immediately and stored properly. Food and liquid temperatures that were missing could only be corrected through immediate staff education. Therefore, an immediate in-service was initiated on the proper documentation of temperatures. The plates on the serving line were stored correctly and the shelf they are stored on</p>		

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	<p>C. Shelves in the dry storage room had a dented can of diced pears, two bags of open undated elbow macaroni, two bottles of open and undated "Designer Dessert" sauce, kiwi flavor.</p> <p>D. On the shelves in the walk-in freezer: one open and undated bag of peas, one open and undated bag of carrots, one open and undated bag of Cinnamon rolls, seven undated bags of broccoli, nine undated bags of corn, eighteen undated bags of cauliflower, twelve undated bag of peas, nine undated bags of lima beans, eight undated bags of brussel sprouts, four undated bags of sweet potatoes, and sixteen undated bags of carrots.</p> <p>An interview with the Dietary Manager, at this time, indicated all open foods, including spices should be closed and dated, dented or bulging cans off food should not be on shelf for use but they should be placed in her office and returned for credit. All foods in walk in freezer and coolers should be closed and dated.</p> <p>On 5/9/14 at 10:45 A.M., an observation of the plates on serving line storage shelf were stored upright on a dirty shelf.</p> <p>During an interview on 5/9/14 at 10:50 AM., the Dietary manager indicated</p>		<p>was immediately cleaned. The kitchen staff were immediately in-serviced on completing the temperature logs. The temperature logs were removed and reinitiated. Resident # 56 and resident # 40 were assessed and demonstrated no negative outcome related to the deficient practice. Employee # 15, employee # 16 were included in an all staff in-service covering the GL Guideline Hand Washing & Other Infection Control Measures During Dining. Resident # 10 and resident # 101 were assessed and neither demonstrated any negative affects from employees # 10, 11, & 12 leaning on their tables talking to them. Employee # 10, employee # 11, and employee # 12 were included in an all staff in-service covering the GL Guideline Hand Washing & Other Infection Control Measures During Dining. II. All residents had the potential to be affected by the deficient practice. Therefore all residents were assessed and none demonstrated negative outcomes related to the deficient practice. III. The dietary staff were in-serviced on GL Guideline Storing Prepared Foods, GL Guideline Labeling & Dating Food Products, and GL Guideline Food Serving & Temperature Logs, and dietary staff will be included in the all staff in-service on GL Guideline Hand Washing. A QAPI tool titled, "F-371, Kitchen Sanitation" was developed that</p>		

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	<p>plates, bowls and coffee carafes should be stored upside down on clean shelves or racks.</p> <p>On 5/9/14 at 11:00 A.M., review of May 2014 All Area Meal Temperature Logs indicated there was missing documentation of full meal temps, including liquids.</p> <p>On 5/9/14 at 11:08 A.M., an interview with the Registered Dietician, indicated all foods hot and cold, should be temped before each meal and documented on log.</p> <p>On 5/13/14 at 8:50 A.M., the Executive Director provided the following undated policy titled: "Dented Cans, Handling Clean Equipment and Utensils, Storing Dry Foods." Review of the policy at this time indicated, "...Cans damaged in the following ways should be stored in the separate area after delivery: All dented cans... store clean and sanitized portable equipment and utensils so that food contact surface are protected from splash, dust and other contaminants...label all open items with date opened...reseal any boxes or bags effectively...."</p> <p>On 5/14/14 at 9:00 A.M., the Executive Director provided the following undated policies titled:"Storage of Frozen Foods" Review of the policy did not indicate that</p>		<p>the Registered Dietician will complete 2 times weekly, times 4 weeks, and the ED will complete 2 times weekly, times 4 weeks, and the Dietary Manager will complete daily, times 4 weeks, on scheduled days of work to monitor compliance with handwashing, temperature log completion, and compliance with food storage regulations. IV. The ED or designee will review findings weekly and will report findings to the QAPI Team monthly for 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p>				

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	<p>frozen foods should be dated, but should be monitored for manufacturer "Best if Used By" Date.</p> <p>2A. On 5/8/14 at 12:15 P.M., Employee #15 was observed washing her hands in the main dining room washing station. Employee #15 washed her hands for 6 seconds and then began serving resident's their food.</p> <p>On 5/12/14 at 12:00 P.M., a policy was received from the Executive Director. Review of the Handwashing policy indicated the following: "... Definition: Handwashing must occur for at least ten to fifteen seconds...."</p> <p>2B. On 5/13/14 at 11:50 A.M. Employee #16 was observed in the B-Wing assisted dining room. Employee#16 pushed resident #56 wheelchair into the dining room, she immediately touched her nose, and she immediately picked up a tray and served it to Resident # 40. At no time was Employee #16 observed washing her hands or using alcohol based hand rubs.</p> <p>On 5/13/14 at 12:14 P.M., Employee #3 indicated the expectation after touching a wheelchair is that they would wash hands before serving food. He further indicated it is an expectation that employees</p>						

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	<p>sanitize hands between residents and wash hands before touching food.</p> <p>On 5/12/14 at 12:13 P.M., a policy was received from the Executive Director. Review of the Handwashing policy indicated the following: "... When appropriate handwashing must be performed at the following times: when coming on duty, whenever hands are obviously soiled, before preparing medication pass, before and after eating, after having prolonged contact with a patient/resident (i.e., bed, bath, changing linen, etc.), upon completion of duty, after personal body function, use of toilet, blowing or wiping the nose, smoking, or combing the hair and before and after all patient/resident care activities...."</p> <p>2C. On 5/8/14 at 12:00 P.M., Employee #10 was observed in the main dining room taking lunch orders. Employee #10 was observed leaning on multiple tables with her forearms stretched out onto the tables while she talked to the residents and took their lunch orders.</p> <p>On 5/8/14 at 12:09 P.M., Employee #11 was observed in the main dining room talking to a resident who was waiting for her meal to be served. Employee #11 was observed leaning on the table of Resident #101 with both of her forearms</p>			

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	<p>stretched out onto the table while she talked to a resident who was awaiting her meal.</p> <p>On 5/8/14 at 12:15 P.M., Employee #12 was observed in the C-wing assisted dining room leaning on the table with both of her forearms stretched out onto the table while she talked to a resident who was awaiting assistance with his meal. When Employee #12 was done talking she sat down to assist the resident without washing her hands.</p> <p>On 5/14/14 at 1:54 P.M. an interview was conducted with the Director of Clinical Education and the Executive Director. The Executive Director indicated staff, no matter who they are should not be leaning on or laying across a table to talk to or to interact with a resident. The Executive Director further indicated there was no policy or procedure for leaning on the tables.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</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> <p>Based on observation, interview and record review, the facility failed to ensure non-medical personnel did not have access to 1 locked medication room. This</p>	F000431	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	06/13/2014			

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	<p>deficient practice had the potential to affect 1 of 2 medication rooms in the facility. (C-wing Medication Room)</p> <p>Findings include:</p> <p>On 5/12/14 at 1:50 P.M., the Maintenance Director was observed in the C-Wing medication room working on the air conditioning unit. LPN #8 and LPN #9 were sitting at the nurse's station facing away from the medication room and talking to each other.</p> <p>On 5/12/14 between 1:50 P.M. and 2:00 P.M., an interview was conducted with the Maintenance Director. The Maintenance Director indicated it was not the facilities practice for non-medical personnel to work unsupervised in the medication room.</p> <p>On 5/12/14 between 2:00 P.M. and 2:10 P.M., an interview was conducted with LPN#8. LPN #8 indicated it was not the facilities practice for non-medical personnel to work unsupervised in the medication room.</p> <p>On 5/12/14 at 2:12 P.M., an interview was conducted with the Executive Director of the facility. The Executive Director indicated non-medical personnel should be supervised when in the</p>		<p>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. It is the practice of this facility to ensure non-medial personnel does not have access to locked medication rooms. Consistent with this practice, the following actions have been taken: I. The Director of Maintenance exited the medication room and was immediately in-serviced on GL Guideline Medication Storage in the Facility 4.1. LPN #8 & LPN #9 were in-serviced on GL Guideline Medication Storage in the Facility 4.1. The medication room was observed to be free of medications outside of the automatic dispensing unit (AUD) located within the medication room. The AUD was observed to be free of signs of tampering and remained locked and functioning properly. II. No other medication rooms were affected by the deficient practice. III. All non-licensened-nursing personnel were in-serviced on GL Guideline Medication Storage in the Facility 4.1. Licensed nursing personnel were in-serviced on GL Guideline Medication Storage in the Facility 4.1. A QAPI tool has been developed to monitor ongoing compliance titled, "F-341 Medication Room Access" that the DNS or designee will utilize to monitor daily, on scheduled days</p>				

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F000441	<p>medication room.</p> <p>On 5/12/14 between 2:15 P.M. and 3:00 P.M., an interview was conducted with LPN #9. LPN #9 indicated the Maintenance Director had asked to get into the medication room. LPN #9 further indicated "... I unlocked the door for him... he was just in there a little bit, about 20 minutes...."</p> <p>On 5/12/14 at 3:30 P.M., review of the Medication Storage in the Facility Storage of Medications policy and procedure dated 05/12, received from the Executive Director, indicated the following: "...B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications, medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access...."</p> <p>3.1-25(m)</p>		<p>of work, times 4 weeks, that only appropriate access is allowed to the medication rooms through observation and staff interviews. IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p>	

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SS=D	<p>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>1. Based on observation and interview, the facility failed to ensure catheter</p>	F000441	Preparation and/or execution of this plan of correction does not constitute admission or	06/13/2014			

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	<p>tubing was kept off the floor. This deficient practice affected 1 of 1 residents observed with catheters. (Resident #101)</p> <p>2. Based on observation, interview and record review, the facility failed to ensure proper infection control procedures related to covering of linen carts.</p> <p>Findings include:</p> <p>1. On 5/8/14 at 11:15 A.M., Resident #101 was observed sitting in the main dining room awaiting her meal. Resident #101 was observed to have her catheter tubing, containing clear yellow urine, and dignity bag resting on the floor of the main dining room.</p> <p>On 5/12/14 at 12:13 P.M., Resident #101 was observed sitting in the main dining room awaiting her meal. Resident #101 was observed to have her catheter tubing, containing clear yellow urine, and dignity bag resting on the floor of the main dining room floor.</p> <p>On 5/14/14 at 1:24 P.M., an interview was conducted with the Unit Manager of the C-Wing. The Unit Manager indicated her expectation is that catheter tubing and dignity bags are to be kept off the floor, it is an infection control issue.</p>		<p>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. It is the practice of this facility to 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. Consistent with this practice, the following actions have been taken: I. Resident #101 was provided with catheter tubing that would not touch the floor and a new dignity bag that had not touched the floor. 2. The linen cart that was observed uncovered during linen distribution was emptied and the linen in the rooms that employee #2 had distributed linens to was removed and redistributed. Employee #2 was in-serviced on Laundry/Linen Distribution Policy. II. All other residents with catheters could have possibly been affected by the deficient practice. Therefore all residents with catheters were observed to ensure that tubing nor bag were dragging the floor and that a dignity bag was in place. All other linen carts were observed and none were found uncovered. III. Staff will be in-serviced on GL Guideline Indwelling Catheter</p>				

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	<p>On 5/14/14 at 2:30 P.M., an interview was conducted with the facility Director of Clinical Education. The Director of Clinical Education indicated her expectation is that catheter tubing and dignity bags be kept off the floor. The Director of Clinical Education indicated she could not locate a policy or procedure that addressed catheter tubing and dignity bags.</p> <p>2. On 5/12/14 at 2:20 P.M., an observation of Employee #2 pushing linen cart down hallway with front of cart uncovered, stopping at 5 rooms to distribute clean linens to resident rooms.</p> <p>On 5/12/14 at 2:30 P.M., an interview with Employee #2 indicated linen carts should be covered at all times except when removing linens.</p> <p>On 5/13/14 at 8:50 A.M., the Executive Director provided the current policy "Laundry/Linen " dated January 11, 2013. Review of the policy at this time indicated, "...The linen cart cover should be placed over the exchange cart and secured to ensure protection of the clean linens...."</p> <p>3.1-41(a)(2) 3.1-19(g)(1)</p>		<p>Care, with special focus on dignity bag, Laundry / Linen Distribution Policy. QAPI tools have been developed to monitor ongoing compliance titled, "F-441 Infection Control" & "F-441 Linen Carts"that the DNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that catheter tubing and bags are maintained in a way that prevents infection and linen carts are maintained in compliance with infection control guidelines through observation and staff interviews. IV. The DNS or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p>				

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to maintain a sanitary, orderly and comfortable interior related to resident rooms being dirty for 18 of 18 rooms observed.</p> <p>Findings include:</p> <p>On 5/8/14 at 2:36 P.M., an observation of the bathroom in Room 207 indicated inside of bathroom door was scuffed and water faucet leaked when water turned on.</p> <p>On 5/08/2014 at 2:58 P.M., an observation of Room 224 indicated the wall that the resident looks at while he is in his bed is marred.</p> <p>On 5/08/2014 at 3:14 P.M., an observation of Room 218 indicated the inside of the bathroom door was marred.</p> <p>During an interview on 5/8/14 at 3:42 P.M., resident #54 indicated "the bathroom could be cleaner". Observation of Resident #54's bathroom indicated the</p>	F000465	<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>It is the practice of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Consistent with this practice, the following actions have been taken:</p> <p>I. The faucet was replaced in room #207 and the door scuffs were repaired and repainted. The wall in room # 224 was repaired. The door inside the bathroom in room # 218 was repaired and repainted. Resident # 54's room and bathroom was observed and a was deep cleaned. The bathroom floor will be replaced and the door and walls were repaired and repainted. The bathroom of room #130 will be repainted. The bathroom door of room # 126 will be repainted. The bathroom and bedroom floors of room #129, #131, #127, #135, and #106 will be deep cleaned, stripped, and waxed. The bathroom walls of room # 223 will be repainted. The bathroom door will</p>	06/13/2014

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	<p>flooring was chipped, dirty and finish worn off, walls, door marred and scuffed.</p> <p>On 5/8/14 at 04:03 P.M., an observation of Room 130 bathroom indicated the paint was peeling off of trim at bottom of walls.</p> <p>On 5/8/14 at 4:08 P.M., an observation of Room 126 indicated the inside of the bathroom door was scuffed.</p> <p>On 5/8/14 at 4:10 P.M., and observation of Room 129 indicated the floor was dirty with debris in corners and the finish on the bathroom floor was worn off.</p> <p>On 5/9/14 at 9:32 A.M., an observation of Room 131 indicated the floor in residents room was dirty with debris in corners, the finish on the bathroom floor was worn off and the bathroom flooring was also chipped, the inside of bathroom door was marred and the doorsill was dirty.</p> <p>On 5/9/14 at 10:15 A.M., an observation of Room 219 indicated inside of the bathroom door is marred and the wall to the right of the toilet just below the grab bar is marred. Non slip tape on grab bar is loose and not adhering to the bar.</p> <p>On 5/9/14 at 11:30 A.M., an observation</p>		<p>be painted in room #216. The bathroom flooring will be repaired in room # 214 and the walls and doors will be painted. The flooring will be repaired in room # 223.</p> <p>II. All resident floors were observed and cleaned as necessary to ensure that floors were free of debris and cleaned appropriately. All resident rooms were observed and an action plan titled, "Environment: Resident Room" was developed to identify, correct, and monitor ongoing painting needs throughout the resident living areas.</p> <p>III. All resident rooms were observed and any necessary cleaning was completed. Environmental staff will be in-serviced on the Cleaning of Resident Room Policy & Procedure. A QAPI tool titled, "Room Cleanliness" was developed that the ED or designee will review daily times 4 weeks, on scheduled days of work to monitor compliance with F-465. An QAPI tool titled, "Environmental Improvement Plan" was developed to track the action plan titled, "Environment: Resident Room" and the preventative maintenance completion log weekly times 4 weeks and monthly thereafter to ensure compliance with Preventative Maintenance Program, including routine work orders.</p>		

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	<p>of Room 221 indicated inside of the bathroom door was marred.</p> <p>On 5/9/14 at 11:02 A.M., an observation of Room 223 indicated the bathroom walls were marred along the bottom.</p> <p>On 5/9/14 at 12:09 P.M., an observation Room 217 indicated bathroom walls were marred and bathroom floor was dirty.</p> <p>On 5/9/14 at 12:18 P.M., an observation of Room 127 indicated floor in resident room dirty with debris in corners, bathroom floor finish worn off and ground in dirt.</p> <p>On 5/9/14 at 12:20 P.M., an observation of Room 106 indicated the floor was dirty with debris in the corners and the bathroom floor finish was worn off.</p> <p>On 5/9/14 at 1:04 P.M., an observation of Room 216 bathroom indicated marring on the inside of bathroom doors.</p> <p>On 5/13/14 at 11:30 A.M., an observation of Room 214 indicated the bathroom flooring was chipped and the walls and door scuffed.</p> <p>On 5/13/14 at 11:32 A.M., an observation of Room 223 indicated the bathroom flooring was chipped.</p>		<p>IV. The ED or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p>	

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F009999	<p>On 5/13/14 at 11:35 A.M., an observation of the shower room doors across from Room 223 indicated the doors were marred and scuffed.</p> <p>On 5/13/14 at 2:45 P.M., an observation of bathroom in Room 135 and interview with the Maintenance Director and Housekeeping Supervisor was conducted. The Housekeeping Supervisor indicated "...they [the floors] should not look like this...." She further indicated the floors should not be chipped, worn, or dirty in appearance. The Maintenance Director indicated scuffs and marred doors should be painted once a month and faucets should not leak.</p> <p>3.1-19(f)</p>	F009999	<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>It is the practice of this facility</p>	06/13/2014			
	<p>3.1-14</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: (7) documentation of orientation to the facility and to the specific job skills</p>						

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	<p>This regulation is not met as indicated by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of Nurse Orientation was complete for 1 of 4 nurse employee records reviewed. (LPN #7)</p> <p>Findings include:</p> <p>On 5-14-14 at 11:00 A.M., record review of employee records showed that the "Nurse Orientation" was only partially filled out for 1 of 4 nurse employee records reviewed.</p> <p>In the file for LPN #7, documentation of completion of the following orientation areas were missing: Service Excellence, Nail/foot care of a diabetic resident, Catheters, Feeding pump, Stool guiac, Dialysis, Collection of lab specimens/lab reports, Immunization record, 24 hour admission, Safety devices, and Smoking.</p> <p>On 5-14-14 at 1:39 P.M., an interview with the DCE (Director of Clinical Education) was conducted. The DCE indicated it was her expectation that orientation checklists are completely filled out and if they weren't she would expect the trainer to go over anything else</p>		<p>to ensure documentation of Nurse Orientation is completed. Consistent with this practice, the following actions have been taken:</p> <p>I. The orientation checklist for nurse # 7 was completed and placed in employee's personnel file.</p> <p>II. All other nurses' employee files were audited to ensure that all orientation checklist were completed.</p> <p>III. The clinical leadership team was provided in-service on required nurse orientation checklist. A QAPI tool titled, "F9999 Orientation Checklist" was developed to ensure that nurse orientation is completed. This will be completed by the ED or designee times 4 weeks with every new hire to monitor compliance with F9999.</p> <p>IV. The ED or designee will review findings weekly and will report to the QAPI Team monthly times 6 months to determine need for continued monitoring thereafter until a threshold of 100% is reached.</p>				

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	<p>they need to until it's done.</p> <p>On 5-14-14 at 2:10 P.M., review of the "Human Resources Management Policies and Procedures Manual", dated July 2009, received from the DCE at this time, indicated "...The Orientation Checklist(s) or other state required orientation checklists will be completed by the employee and trainer and will be filed in the employee's personnel file...."</p> <p>3.1-14(q)(7)</p>				