

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2014
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NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates November 16, 17, 18, 19, 20 & 21, 2014.</p> <p>Facility number: 000522 Provider number: 155479 AIM number: 100267040</p> <p>Survey Team: Virginia Terveer, RN, TC Sue Brooker, RD Julie Call, RN Martha Saull, RN</p> <p>Census Bed type: SNF: 45 SNF/NF: 79 Total: 124</p> <p>Census payor type: Medicare: 34 Medicaid: 65 Other: 25 Total: 124</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December</p>	F000000	<p>Enclosed is the plan of correction for the survey completed at Kingston Care Center on 11-21-14. Please consider this the facility's credible allegation of compliance. However, submission of this response and the plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be constructed as an admission of interest against the facility, the administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Rather, this plan of correction has been prepared because the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000241 SS=D	<p>1, 2014 by Randy Fry RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review the facility failed to ensure the dignity of 4 residents who required assistance from staff at mealtime.</p> <p>Findings include:</p> <p>1. During an observation of the evening meal on 11/17/14 in the Royal Cafe Dining Room, the following was observed:</p> <ul style="list-style-type: none"> - At 5:55 p.m., a resident was observed seated in her wheelchair in the Royal Cafe Dining Room. RN #1 was observed next to and standing above the resident while giving her sips of her liquid. - At 5:59 p.m., a resident was observed 	F000241	<p>Staff members assigned to assist with feeding a resident have been re-trained on dignity and respect with feeding related to not standing while assisting with feeding. The Staff Development nurse will complete training with nursing staff on or before December 19th 2014. Assistive dining will be monitored at random meals three times a week for 30 days, weekly for 3 months, and monthly for 2 months by the Director of Nursing Services or designee. Audits will be discussed monthly at the quality assurance meeting.</p>	12/21/2014

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	<p>seated in her wheelchair in the Royal Cafe Dining Room. Certified Nursing Assistant (CNA) #2 was observed next to and standing above the resident feeding her.</p> <p>- At 6:08 p.m., a resident was observed seated in her wheelchair in the Royal Cafe Dining Room. CNA #3 was observed next to and standing above the resident feeding her.</p> <p>2. During an observation of the breakfast meal on 11/18/14 in the Royal Cafe Dining Room, the following was observed:</p> <p>- At 8:28 a.m., a resident was observed seated in her wheelchair in the Royal Cafe Dining room from the hallway outside the dining room. CNA #4 was observed next to and standing above the resident feeding her.</p> <p>- At 8:32 a.m., the surveyor entered the dining room and observed CNA #4 standing next to and above the same resident feeding her. When CNA #4 noticed the surveyor she pulled a chair over and sat down next to the resident to continue feeding her breakfast.</p> <p>The Administrator and Director of Nursing were interviewed on 11/21/14 at</p>			

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F000248 SS=D	<p>2:42 p.m. During the interview they indicated staff were to be seated when feeding residents.</p> <p>A current undated facility policy "Resident's Rights", provided by the Administrator on 11/20/14 at 4:12 p.m., indicated "...Residents have the right to a dignified existence..."</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure a cognitively impaired resident was provided opportunity and/or encouragement to attend facility activities for 2 of 9 residents who met the criteria for activities. (Resident #104 and #202)</p> <p>Findings include:</p> <p>1. On 11/20/14 at 2 p.m. the clinical</p>	F000248	For resident #104 and resident #202 their care plans have been updated to reflect their individual activities preferences. Room bound residents have had their activity care plans reviewed and updated for individual preferences. Staff and volunteers assigned to provide activities will be trained on 1:1 visit logs and documentation of offers and refusals of activities participation by December 19th 2014. The Activity Director will audit the	12/21/2014

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	<p>record of Resident #104 was reviewed. Diagnoses included, but were not limited to, the following: depressive disorder, anxiety, persistent mental disorder. The MDS (minimum data set) assessment dated 8/2/14 included, but was not limited to, the following: severely impaired cognition; no signs and symptoms of mood issues present; physical behavior directed toward others occurred 1-3 days; transfer and locomotion on and off unit required extensive assist.</p> <p>An activity progress note dated 11/5/14 included but was not limited to, the following: "(resident name) is slowly declining away from our programs...We still encourage music programs even for a short time..."</p> <p>On 11/19/14 at 8:45 a.m. the resident was observed in her room in her low bed. From the entry door to the room, the resident's bed was positioned with the head of her bed flat against the far side of the wall and the left side of her bed was up against the right wall, in the far right corner of the room. Angled across the far left corner of the room was a chest high dresser (for a 5 foot 2 inch person) with the TV on top of it. For the resident to view the television, the resident would either have to lay on her right side and or</p>		<p>activity participation logs for room bound residents three times a week for 30 days, weekly for 2 months and monthly for 3 months. Audit findings will be discussed monthly at the quality assurance meeting.</p>	

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	<p>turn her head to the right.</p> <p>On 11/20/14 at 10 a.m. the Activity Director (AD) provided a current copy of the resident's care plan, dated 11/7/13, for activities with the following focus: "I need diversional activities r/t (related to) anticipated long term stay...I am able to structure my own leisure. I have limited vision/hearing...love pet visits..." The goal was documented as "...will pursue independent activities AEB (as evidenced by) TV, radio, visits...will be aware of group activity opportunities and materials available to her for independent leisure pursuits during stay..."</p> <p>On 11/20/14 at 3:50 p.m. the Activity Director (AD) and Activity Assistant (AA) were interviewed. At the time, she provided copies of the resident's activity attendance logs for the last 3 months. These logs included the following: For the entire month of September 2014, the resident attended one activity on 9/22/14 of "friendly visit" and was documented as actively participating. For the entire month of October 2014, the resident attended two activities, on 10/23/14 a music activity and on 10/24/14 a "friendly visit." For the month of November 2014 to date, the resident attended one activity so far on 11/6/14 and this was "friendly visit."</p>			

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	<p>Documentation was lacking on the logs of the resident having been offered and/or refused activities. At the time, the AD indicated she was unaware the resident had only attended 4 activities in the last 3 months. At the time, the AD indicated it would be good to at least offer the resident more than 4 activities in 3 months. She indicated they do go to her room and offer for the resident to go to activities but documentation was lacking of that having been done. Regarding a goal as to the residents attending activities, the AD indicated she felt like a reasonable goal would be to encourage and offer the resident to come to activities.</p> <p>On 11/20/2014 at 3:50 p.m., the current activity calendar was reviewed. On 11/3/14 and 11/17/14 at 6:30 p.m., was the activity of "Visiting dogs - in room." Documentation was lacking on the resident's attendance record she had been offered this activity and participated in this activity. This was identified on her plan of care as an activity she would potentially have had an interest in. Also on 11/5/14, 11/6/14, 11/7/14, 11/12/14, 11/13/14, 11/14/14, 11/18/14 and 11/19/14 was the activity of "Music..." Documentation was lacking the resident was encouraged and/or refused to attend the activity.</p>						

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	<p>2. Review of the clinical record for Resident #202 on 11/21/14 at 1:00 p.m., indicated the following: diagnoses included, but were not limited to, anoxic brain damage, Parkinson's Disease, chronic respiratory failure, dysphagia, gastrostomy.</p> <p>A Minimum Data Set (MDS) assessment for Resident #202, dated 10/5/14, indicated the Resident was not comatose or in a persistent vegetative state. It also indicated the Resident had no speech/absence of spoken words and rarely/never understands others. The MDS, dated 9/23/14 indicated the Resident could not be interviewed for the Brief Interview for Mental Status (BIMS) because the Resident could rarely be understood.</p> <p>During multiple observations on 11/17/14 and 11/18/14, Resident #202 was not observed being provided 1:1 activities. The resident's roommate's television was on but was not visible and not audible for the resident.</p> <p>An observation on 11/19/14 at 1:30 p.m., indicated Resident #202 was resting in his bed on his right side, facing the privacy curtain with his eyes open. The privacy curtain was pulled to the middle</p>			

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	<p>of the room. The roommate's television was not in Resident's view and the television was difficult to hear.</p> <p>A review of Resident #202's Activity Participation Logs for September, October and November 2014, the documentation indicated, "No Records Found"</p> <p>An observation on 11/20/14 at 2:30 p.m., indicated Resident #202 was resting in his bed with the head of the bed in the up position approximately 45 degrees. The privacy curtain was pulled to the middle of the room. The Resident's television was not on but his Roommate's television was on and out of view of the resident.</p> <p>An observation on 11/21/14 at 1:40 p.m., indicated Resident #202 was in bed, resting on his right side, facing the privacy curtain. The Roommate's television was on but could not be heard on the Resident's side of the room. The television was not in the view of the resident with the privacy curtain pulled.</p> <p>An interview with the Activity Director (AD) on 11/21/14 at 2:00 p.m., indicated the facility's activity staff does not provide 1:1 activities with the Residents. She indicated the volunteers who come provide 1:1's with the Residents. She</p>			

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	<p>indicated the Volunteers are not assigned specific residents and come randomly to visit with the Residents She indicated the Volunteers talk with the Residents and can read to them. She indicated Resident #202 has had pet visits and strolling musicians in the past. She indicated she had a massage therapist see Resident #202 and she provided a hand massage for him. She indicated the Resident did not respond to the massage so they have not tried it again.</p> <p>An interview with the AD on 11/21/14 at 2:10 p.m., indicated the Activity Log was blank for Resident #202. She indicated the activity staff had not documented if he had any activities. She indicated it was the responsibility of the 4 Activity Staff to document any activity provided for the Resident. She indicated the pet visits and strolling musicians should have been documented on the Activity Log.</p> <p>During an interview with the AD on 11/21/14 at 2:48 p.m., the AD provided a list for the Volunteers of the Resident's who require Structured 1:1 visits. She indicated Resident #202 was listed for the Volunteers to visit. She indicated she did not have any documentation by the Volunteers that Resident #202 had 1:1 structured activities.</p>			

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	<p>A review of the List of Resident requiring structured 1:1 Visits, provided by the AD on 11/21/14 at 2:48 p.m., indicated Resident #202's name was on the list and indicated the following, "...These residents are care planned for 1:1 visits weekly. You must chart 1:1 visit in attendance log as well as a 1:1 response in the response log...Interest...music, read to, pets, non verbal..."</p> <p>A review of the Volunteer Sign-In-Log for July, August, September, October and November 2014, provided by the AD on 11/21/14 at 2:48 p.m., indicated the following, "...Date, Name/Group, Type of Activity, Hours In and Out, Total Hours..." The AD indicated the form did not list Resident's the Volunteer had 1:1 visits with.</p> <p>A review of the Activity Care Plan for Resident #202 on 11/21/14 at 1:00 p.m. indicated the following, "...Resident needs socialization and diversional activities related to physical status. Prefers room. Personal Preferences...Goals: Resident will accept and be responsive to friendly 1:1 visits weekly with activity staff, volunteers and room to room entertainment and pet visits as available: Interventions: Offer activity interventions (i.e. TV, VCR movies, radio, games, books, other</p>			

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	<p>reading materials, etc.) of resident's choice....Provide resident with monthly activity calendar (large print as needed)...Visit to talk, encourage and support resident...."</p> <p>On 11/20/14 at 3:50 p.m. the AD provided a current copy of the facility policy and procedure for Activities/General. This policy was dated 6/20/14 and included but was not limited to, the following: "...facility must provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental and psychosocial well-being of each resident and the facility shall have the plan of activities appropriate to the needs of the resident...that include but is not limited to, the following:...group social activities...1:1 attention...at least 30 minutes of staff time shall be provided per resident per week for activity duties...participation shall be encouraged... assessing resident needs and developing resident activities goals for the written care plan; review goals and progress notes..."</p> <p>On 11/20/14 at 3:50 p.m. the AD also provided a copy of the current, undated facility policy and procedure for "Individual and Room bound Activities."</p>			

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	<p>This policy included but was not limited to, the following: "Provide adequate activity contacts and/or opportunities to those residents who are unable to leave, or who choose to stay primarily in their own rooms. The activities shall be reflective of each Resident's individual activity interests. The full realm of activity programs that are offered to Resident's in group settings are offered with adaptations and modifications to residents who are room bound and or bed bound or prefer to remain primarily in their rooms. The Activity staff will perform the following duties: maintain communication with the nursing department to keep appraised of residents who are physically unable to leave their rooms...maintain a record of residents who choose not to leave their room...who have patters (sic) of low participation...provide 1:1 based activity programs to the above stated residents...provide activity contact according to each resident's...needs...may include...musical tapes, stimulation of the five senses (touch, taste, smell, hearing and sight)...Use the activity care plan as a guide to each Resident's activity care needs...Maintain a record of Resident's receiving room visits in the Activity office..."</p> <p>3.1-33(a)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review,</p>	F000279	Resident #32 care plan has been updated to reflect hypnotic use. Residents on hypnotics have	12/21/2014

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	<p>the facility failed to develop a care plan for the use of a hypnotic medication for insomnia for 1 of 5 residents who met the criteria for unnecessary medication (Resident #32).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #32 on 11/18/14 at 3:26 p.m., indicated the following: diagnoses included, but were not limited to, dementia, depressive disorder, and insomnia.</p> <p>A physician's order for Resident #32, dated 3/10/14, indicated Lunesta 1 mg (milligram) HS (hour of sleep) for insomnia.</p> <p>A Nurse Practitioner Progress Note for Resident #32, dated 3/14/14, indicated per resident's family member she had a problem with insomnia. The note also indicated she had been taking Melatonin but was not sleeping well. The note further indicated she was sleeping well with the medication of Lunesta.</p> <p>EMar (electronic medication administration record) notes for Resident #32, dated 3/24/14, 3/29/14, and 3/30/14, indicated she was unable to sleep.</p> <p>An Alert Listing Report for Resident #32,</p>		<p>been reviewed for an appropriate plan of care. Nursing staff will be educated on care planning the use of hypnotics by December 19th 2014. The Clinical Directors or designee will audit hypnotic orders for appropriate care plans for all hypnotic use three times a week for 30 days and weekly for 5 months with audit findings discussed at monthly quality assurance meeting monthly.</p>				

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	<p>dated 4/28/14, indicated she was up until late, approximately 2:00 a.m.</p> <p>A Nurse Practitioner Progress Note for Resident #32, dated 6/16/14, indicated a telephone call was received from a family member. The family member stated (the resident) was not sleeping at night. The family member also indicated insomnia had been an on-going problem for (the resident) and several medications had been tried for insomnia. The note further indicated the resident was not sleeping at night per her roommate. The note recommended increasing Lunesta to 2 mg HS.</p> <p>A physician's order for Resident #32, dated 6/16/14, indicated to discontinue Lunesta 1 mg HS and to start Lunesta 2 mg HS for insomnia.</p> <p>An Alert Listing Report for Resident #32, dated 7/13/14, indicated she was up and awake until 4:00 a.m.</p> <p>An Alert Listing Report for Resident #32, dated 8/21/14, indicated she was up and awake until 4:30 a.m.</p> <p>The Director of Nursing was interviewed on 11/20/14 at 4:15 p.m. During the interview she indicated a care plan for insomnia had not been developed for</p>			

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F000282 SS=E	<p>Resident #32.</p> <p>A current facility policy "Care Plans - Comprehensive", with a revision date of October 2010 and provided by the Director of Nursing on 11/21/14 at 9:14 a.m., indicated "...An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's</p>			

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	<p>written plan of care.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure a resident with a seat belt restraint had the restraint released every 2 hours for 2 of 2 resident's reviewed with restraints. (Resident #35, Resident #152)</p> <p>B. Based on interview and record review, the facility failed to ensure a physician order was followed for a lab test to monitor the dosage of a blood thinner (Coumadin) for 1 of 1 residents reviewed on Coumadin. (Resident #203)</p> <p>C. Based on observation, interview and record review, the facility failed to ensure a care plan for a resident on dialysis was followed for assessment of the dialysis access port for 1 of 1 resident reviewed for dialysis. (Resident #271)</p> <p>Findings include:</p> <p>A. 1. On 11/19/14 at 8:30 a.m. the clinical record of Resident # 35 was reviewed. Diagnoses included but were not limited to, the following: Alzheimer's disease and Parkinson's disease.</p> <p>The MDS (Minimum data set) assessment dated 8/22/14 indicated the resident had a BIMS (Brief Interview for</p>	F000282	Resident #35 and #152 seat belts have been released, skin assessed, and been re-evaluated for least restrictive device necessary. Residents utilizing a restraint have been re-assessed for least restrictive device. Resident #203 physician's orders were reviewed related to lab testing for monitoring the dosage of Coumadin administration and the orders have been followed. Resident's receiving Coumadin have also been audited to ensure the physician order for lab testing has been followed. Resident # 271 has discharged. For residents receiving dialysis their care plans have been reviewed to include an assessment of the access port when the resident returns from dialysis. The treatment records for the dialysis patients will show the documentation by the nurse that the nurse has assessed the access port when the resident returned from dialysis. Nursing staff will be educated by December 19th 2014 on releasing a resident using a restraint every two hours and the documentation that is needed to acknowledge the release occurred. Also included in the education will include the required lab testing that is ordered by the physician concerning Coumadin dosing and the dialysis assessment of the access port upon returning to the facility and the required	12/21/2014

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	<p>Mental Status) of 15/15 which indicated independent cognition. However, the MDS indicated the following "signs and symptoms of delirium behaviors present, fluctuates (comes and goes and changes in severity) such as inattention, disorganized thinking, altered level of consciousness and/or psycho-motor retardation were present .</p> <p>A physician order, dated 9/8/14 indicated the following: "Self Release seat-belt, check function q (every) shift, remove q 2 hours and reposition while in WC (wheelchair).</p> <p>On 11/19/14 at 8:50 a.m. the resident was observed to be pushed to the 400 unit by CNA (certified nursing assistant)#33, near the nurses station. The resident was observed at the time to have a fastened seat belt resting over her lap while the resident sat in her WC. The resident continued to be observed in this area and from 9:31 a.m. to 10:04 a.m. the resident remained in this area as the Activity Assistant was visiting with this resident and a group of other residents sitting near the nurses station. The resident was observed to remain in this area with her seat belt fastened. At 11:01 a.m. the resident was observed to receive her medication in the area by the nurses station where she had been since having</p>		documentation. The Clinical Directors or designee will audit restraint release and documentation, coumadin dosing orders follow through, and dialysis access port assessment and care planning three times a week for 30 days, weekly for 2 months, and monthly for 3 months with audit findings brought to monthly quality assurance meeting.	

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	<p>been pushed from the dining room at 8:50 a.m. At 11:17 a.m. the resident remained in the area by the 400 hall nurses station. At 11:30 a.m. the resident the was observed having been pushed in her WC to the dining room. She was observed at this time with the seatbelt fastened over her lap in the wheelchair.</p> <p>On 11/19/14 at 11:55 a.m. the resident was observed in the dining room with a clothing protector covering her lap and front. At 12:20 p.m. the resident was observed in her wheelchair at the table with her seat belt fastened over her lap while she was eating. The seat belt had not been removed from 8:50 a.m. through 12:20 p.m.</p> <p>On 11/20/14 at 9:03 a.m. QMA (Qualified Medical Assistant)#34 was interviewed. She indicated she has cared for the resident in the past. She indicated they were to release the resident's seat belt at least q 2 hours to "readjust" her but sometimes they do it every hour due to her positioning in the wheelchair.</p> <p>On 11/20/14 at 9:07 a.m. the DON (Director of Nursing) was interviewed. She indicated the seat belt was considered a restraint for this resident and staff was supposed to release the seat belt every 2 hours and reposition the resident.</p>			

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	<p>The DON indicated the CNAs had a form, which told them specifics about the resident. The DON indicated they typically don't release the seat belt at the table due to the resident's diagnosis of Parkinson's. The DON indicated if it would not be a problem and/or danger with positioning to take the seat belt off, then they would take it off at the table.</p> <p>On 11/20/14 at 10 a.m., the DON provided a current copy of the facility policy and procedure for "Physical Restraint Application." This policy was dated October 2010 and included but was not limited to, the following: "...Remove the restraint every 2 hours for at least 10 minutes and change the resident's position. Exercise the resident..."</p> <p>On 11/21/14 at 10:20 a.m. the 400 Hall Unit Manager (UM) provided a current copy of the CNA (certified nursing assistant) assignment sheet. This form indicated the following for the resident: "Remove self releasing seatbelt q (every) 2 hours while up in WC (wheelchair) and check skin for breakdown..."</p> <p>A.2. On 11/19/14 at 2:30 p.m., the clinical record of Resident # 152 was reviewed. Diagnoses included but were not limited to, the following: Osteoporosis, abnormal posture, aftercare</p>			

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	<p>for healing traumatic fracture of hip. The MDS dated 9/16/14 indicated the resident had moderately impaired cognition.</p> <p>On 11/19/14 at 8:15 a.m. the resident was observed in the dining room at the table eating. She was in her WC (wheelchair) with a waist restraint which went across her lap in the WC with each end of the restraint going around behind the WC and criss crossing while ends of the belt were attached at the bottom back bars of the wheelchair, out of reach of the resident. At 8:35 a.m., the resident was observed to self propelled herself back to her room in her WC. At 8:45 a.m., CNA #35 was observed to go into the room. At 8:53 a.m. when CNA #35 exited the room, she was interviewed and indicated she had assisted Resident #152's roommate and not provided care for Resident #152. The resident was observed to remain in her room in her WC with the criss cross restraint on at 9:39 a.m. At 9:57 a.m., the resident remained in her room in her WC with the criss cross restraint belt in place. At 10:27 a.m. CNA # 35 was observed to go into the room and pass ice water. She was in and out of the room in under a minute.</p> <p>On 11/19/14 at 10:49 a.m. the resident was observed in the bathroom in her</p>			

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	<p>room unattended. She remained in her wheelchair and continued to have her criss cross restraint on.</p> <p>On 11/19/14 at 10:53 a.m. the CNA #36 was observed to push the resident out of her room in her WC with the criss cross restraint still on and push her into the dining room. At 11:18 a.m. the resident remained in the dining room in her WC with the criss cross belt on</p> <p>On 11/19/14 at 11:23 a.m. CNA #36 was interviewed. She indicated she had not provided any care to the resident this morning.</p> <p>On 11/19/14 at 11:34 a.m. the resident was observed in the main dining room feeding herself at the table. She continued to have the criss cross restraint seat belt secured on her wheelchair.</p> <p>On 11/19/14 at 11:42 a.m. the resident was no longer observed in the dining room. At 11:44 a.m. the resident was observed in her bathroom on the toilet with CNA #37 assisting her.</p> <p>On 11/21/14 at 9 :11 a.m. the 400 Hall UM was interviewed. He indicated the criss cross restraint should be released at least every 2 hours.</p>			

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	<p>On 11/21/14 at 10:20 a.m. the 400 Hall UM (Unit Manager) provided a current copy of the resident's plan of care to address falls. This plan of care was dated 3/11/14 and included but was not limited to the following interventions: "Criss cross restraint on while up in WC , remove q 2 hours for toileting, repositioning and skin assessment..."</p> <p>B.1. On 11/19/14 at 3 p.m. the clinical record of Resident #203 was reviewed. Diagnoses included, but were not limited to, the following: late effects of stroke, hyperlipidemia, recent surgery of below the knee amputation.</p> <p>A plan of care, dated 10/25/14, addressed the focus of "Resident at risk for pulmonary embolism..." Interventions included, but were not limited to, the following: "Monitor labs as ordered and notify physician of abnormalities..."</p> <p>A physician order dated 10/28/14 indicated the following: "Give Coumadin 10 mg...x1 dose today. Starting...10/29/14...Coumadin 7 mg...qd (every day)..PT/INR (prothrombin time/international ratio) Friday 10/31/14. " This order had been signed by the physician on 10/28/14 and had "signature of nurse receiving order" as 3:30 p.m. The area for "med/tx sheet" and "nurses</p>			

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	<p>notes" on this form had been checked.</p> <p>A (name of hospital) "Health Laboratories" form dated 10/31/14 indicated the following labs were to be done: complete blood count and a basic metabolic panel. Documentation was lacking on this form of a PT/INR having been ordered.</p> <p>A physician order dated 11/4/14 indicated the following: "Stat PT/INR, drawn 1600 (4 p.m.)."</p> <p>A PT/INR lab result dated 11/4/14 indicated the following: PT result 16.1, result was high; preference range was 9.6 - 11.6 seconds. The INR result was 1.5, result was high; preference range was 0.9 - 1.1.</p> <p>A physician order dated 11/4/14 indicated the following: "Coumadin 7.5 mg dly, recheck on Friday."</p> <p>On 11/19/14 at 2 p.m. the DON was interviewed. She indicated the PT/INRs were ordered specifically and not on a routine basis. At the time, she reviewed the clinical record and indicated the resident had a physician order to have a PT/INR done on 10/31/14 but documentation was lacking of a lab result for that specific lab having been done on</p>			

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	<p>10/31/14. The most recent PT/INR having been done on the chart before the 10/31/14 was on 10/28/14. The DON indicated sometimes a "fingerstick" type procedure will be done at the facility to check the PT/INR levels. She indicated the machine used for the fingerstick PT/INR reads out a result on the machine on which the fingerstick was performed on at the facility. At the time, she reviewed the clinical record and documentation was lacking of a fingerstick PT/INR having been done on the resident on 10/31/14.</p> <p>On 11/19/14 at 2:30 p.m. the nurses note for 10/31/14 was reviewed. Documentation was lacking of the PT/INR having been drawn.</p> <p>A form (untitled) was reviewed on 11/19/14 at 3 p.m. and included, but was not limited to, the following information: "Resident diagnosis for the use of Anticoagulant...physician parameters for PT...date, name of medication, current dose from MAR, current PT results, current INR results...physician...notified via phone or fax...new orders received..." This form included but was not limited to the following dated lab results: 10/24/14, Warfarin (Coumadin) 6 mg...recheck on 10/28/14." Documentation was lacking on this form of the PT/INR completed on</p>			

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	<p>10/28/14. Documentation was lacking on this form of a PT/INR having been completed on 10/31/14. The next documented entry was 11/4/14: "Coumadin 7 mg, PT 16.1, INR 1.5...</p> <p>On 11/19/14 at 3:45 p.m. the DON was interviewed. She indicated she had called the hospital and they did not draw the PT/INR on 10/31/14. She also indicated she was unsure why the stat (immediately) PT/INR was ordered on 11/4/14 as the resident was not in distress at the time.</p> <p>On 11/21/14 at 1:25 p.m. the DON (Director of Nursing) provided a current copy of the policy and procedure for "Anticoagulation - clinical protocol." This policy was dated October 2010 and included, but was not limited to, the following: "...the physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example periodically checking...PT (prothrombin time)/INR (international ratio)..."</p> <p>On 11/21/14 at 1:25 p.m. the DON provided a copy of the policy and procedure for "Physician Medication Orders" dated April 2010. The policy included but was not limited to, the following: "...All drug...orders shall be</p>			

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	<p>written, dated, and signed by the person lawfully authorized to give such an order...verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the date and time of the order..."</p> <p>C. An interview with LPN #33 on 11-17-2014 at 2:58 p.m., indicated Resident #271 had dialysis on Mondays, Wednesdays and Fridays from 5:25 a.m. and returns around 10:30 a.m.</p> <p>The record review began on 11-19-2014 at 4:20 p.m. and indicated diagnoses included but were not limited to rehabilitation, aftercare following surgery, end stage renal disease, cardiac pacemaker, peritonitis, depression, chronic venous embolism and thrombosis of internal jugular veins and chronic hepatitis.</p> <p>A review of the green dialysis communication binder for Resident #271 indicated vitals signs and weights were completed prior to and post dialysis for the following dates: 11-5,12,14,17 and 18, 2014.</p> <p>A dialysis care plan dated 10-30-2014 and provided by the DON on 11-21-2014 at 8:00 a.m., indicated the following</p>			

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	<p>interventions/tasks:</p> <ul style="list-style-type: none"> - "coordinate care with dialysis center and nephrologist as needed/indicated - medications as ordered - observe for s/s (signs/symptoms) decreased circulation to affected extremity and notify physician if observed - observe for s/s fluid volume overload, notify physician if ordered - weights as ordered - assess port/AV (arteriovenous) fistula site daily for s/s infection - no blood draws, IVs (intravenous), BPs (Blood Pressure) in extremity with fistula/port - assess port/fistula site after dialysis to assess for complications - document use of pharmacological and non-pharmalogical interventions...being used. - document assist needed...." <p>A review of the nurse progress notes indicated no daily assessment of the port since the last admission on 10-30-2014 for the following dates:</p> <p>10-31-2014 11-2-2014 11-4-2014 11-8-2014 11-11-2014 11-13-2014 11-14-2014</p>			

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	<p>11-16-2014 11-17-2014 11-18-2014 11-19-2014 11-20-2014</p> <p>A review of the nurse progress notes indicated there was no documentation of the post dialysis port site for the following dialysis dates: 10-31-2014 11-10-2014 11-12-2014 11-14-2014 11-17-2014 11-19-2014</p> <p>An interview with the facility Quality Assurance Manager and the DON on 11-20-2014 at 3:00 p.m., indicated they were not sure where the documentation for the fistula/port site was recorded for Resident #271.</p> <p>An interview with RN #1 and LPN #28 on 11-20-2014 at 3:15 p.m., indicated they did not know where the fistula/port assessment was documented.</p> <p>An interview with LPN #28 on 11-21-2014 at 9:05 a.m., indicated Resident #271 went to dialysis and the dressing to the port on the right clavicle was to be done by dialysis. LPN #28</p>			

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	<p>indicated the dressing was intact when the resident left and when the resident returns, LPN #28 indicated the port dressing should be assessed.</p> <p>An interview with the DON on 11-21-2014 at 12:00 p.m., indicated she would expect the care plan to be followed for Resident #271 for dialysis.</p> <p>A current policy "Hemodialysis Access Care" dated October 2010 and provided by the DON on 11-21-2014 at 9:15 a.m., indicated "...the general medical nurse should document in the resident's medical record every shift as follows:</p> <ol style="list-style-type: none"> 1. Location of catheter 2. Condition of dressing (interventions if needed) 3. If dialysis was done during the shift 4. Any part of report from dialysis nurse post-dialysis being given 5. Observations post-dialysis...." <p>3.1-35(g(2))</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure for proper wheelchair positioning and support for one of one resident reviewed for positioning in their wheelchair (Resident 57).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #57 on 11/20/14 at 3:07 p.m., indicated the following: diagnoses included, but were not limited to, presenile dementia and esophageal reflux.</p> <p>A Minimum Data Set (MDS) assessment for Resident #57, dated 8/2/14, indicated she required extensive assistance with the physical assistance of 1 staff for transfers and locomotion. The MDS also indicated she utilized a wheelchair.</p> <p>During an observation on 11/19/14 at 12:18 p.m., Resident #57 was observed</p>	F000309	Resident #57 was provided with a proper fitting wheelchair. Residents who use wheelchairs have been assessed for proper foot support while sitting in the wheelchair. Nursing staff will be educated on proper foot support while in wheelchair by December 19th 2014. The Clinical Directors or designee will audit residents' foot support while in wheelchairs three times a week for 30 days, weekly for 2 months, and monthly for 3 months with audit findings brought to monthly quality assurance meeting.	12/21/2014

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	<p>seated in her wheelchair at a dining table in the Royal Cafe Dining Room. Due to her short stature her feet were observed dangling approximately 1-2 inches above the floor without any support under her feet to stabilize her posture. Her back was not touching the back of the wheelchair and she was observed to lean into the table.</p> <p>During an observation on 11/20/14 at 7:58 a.m., Resident #57 was observed seated in her wheelchair at a dining table in the Royal Cafe Dining Room. Due to her short stature her feet were observed dangling approximately 1-2 inches above the floor without any support under her feet to stabilize her posture. Her back was not touching the back of the wheelchair and she was observed to lean into the table.</p> <p>During an observation on 11/20/14 at 10:00 a.m., Resident #57's wheelchair was observed in her room while Resident #57 was observed resting in bed. There were no footrests or any leg support observed on her wheelchair.</p> <p>During an observation on 11/20/14 at 12:21 p.m., Resident #57 was observed seated in her wheelchair at a dining table in the Royal Cafe Dining Room. Due to her short stature her feet were observed</p>			

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	<p>dangling approximately 1-2 inches above the floor without any support under her feet to stabilize her posture. Her back was not touching the back of the wheelchair and she was observed to lean into the table.</p> <p>During an observation on 11/20/14 at 1:53 p.m. in the Crown Dining Room, Resident #57 was observed attending a music program which lasted approximately 1 hour. Due to her short stature her feet were observed dangling approximately 1-2 inches above the floor without any support under her feet to stabilize her posture.</p> <p>A facility care plan for Resident #57, with a review date of 8/8/14, indicated the focus area of resident requires ADL (activities of daily living) assist related to: dementia, osteoporosis, and congestive heart failure. Interventions to the focus included, but were not limited to, document assist needed and staff assist needed for transfers and wheelchair locomotion.</p> <p>Physical Therapist #17 was interviewed on 11/20/14 at 3:00 p.m. During the interview she indicated residents in wheelchairs should have support under their feet to help stabilize their posture and maintain their balance.</p>			

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	<p>A current facility policy "Rehabilitation Services", with a revision date of 4/18/11 and provided by the Director of Nursing on 4/18/11, indicated "...Positioning programs are provided for a variety of reasons including, but not limited to pressure relief, promoting proper body alignment, proving support, pain relief, providing patient/resident comfort, and providing improved functional status. Each program is designed specifically for each individual patient/resident with respect to his/her medical status and rehabilitation needs...."</p> <p>3.1-37(a)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review the facility failed to keep the indwelling urinary catheter tubing off the floor for 1 of 1 resident (Resident #7) reviewed for catheters.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #7 on 11/19/14 at 9:40 a.m., indicated the following: diagnosis included, but were not limited to, multiple sclerosis, diabetes mellitus and urinary retention secondary to multiple sclerosis.</p>	F000315	Resident #7 catheter tubing has been positioned where it does not graze the floor. Residents with indwelling catheters have been assessed to ensure proper tubing placement. Nursing staff will be educated on proper catheter tubing by December 19th 2014. The Clinical Directors or designee will audit random residents' catheter tubing placement three times a week for 30 days, weekly for 2 months, and monthly for 3 months with audit findings brought to monthly quality assurance meeting.	12/21/2014

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	<p>A physician's order for Resident #7, dated 3/27/14, indicated a Foley catheter. The order also indicated catheter care every shift.</p> <p>During observations on 11/17/14, the following were observed:</p> <ul style="list-style-type: none"> - At 11:36 a.m., Resident #7 was observed seated in her wheelchair in the Crown Dining Room. Her catheter tubing was observed touching the floor. - At 11:38 p.m., Resident #7 propelled herself in her wheelchair from the Crown Dining Room to the Royal Cafe Dining Room to attend a group activity. Her catheter tubing was observed dragging on the floor. - At 11:50 a.m., the activity finished in the Royal Cafe Dining Room. Resident #7 was observed to propel herself in her wheelchair from the dining room through several hallways to the front lobby of the facility. Her catheter tubing was observed dragging on the floor. - At 1:40 p.m., Resident #7 was observed propelling herself in her wheelchair through several hallways in the facility. Her catheter tubing was observed dragging on the floor. 			

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	<p>- At 2:08 p.m., Resident #7 was observed seated in her wheelchair in a small lounge area watching television. Her catheter tubing was observed touching the floor.</p> <p>During an observation on 11/18/14, the following was observed:</p> <p>- At 1:30 p.m., Resident #7 was observed seated in her wheelchair in a small lounge area watching television. Her catheter tubing was observed touching on the floor.</p> <p>During an observation on 11/19/14, the following was observed:</p> <p>- At 8:28 a.m., Resident #7 was observed seated in her wheelchair in the hallway in front of the door to the Activity office. Her catheter tubing was observed touching on the floor.</p> <p>A facility care plan for Resident #7, with a review date of 11/13/14, indicated the focus area of resident requires a catheter. Interventions to the focus included, but were not limited to, catheter care every shift and PRN (as needed), cover drainage bag to promote dignity, keep tubing free of kinks, and keep drainage bag below the level of the bladder. The</p>			

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	<p>care plan did not indicate to keep the catheter tubing off the floor.</p> <p>The Administrator and the Director of Nursing were interviewed on 11/20/14 at 2:44 p.m. During the interview they indicated catheter tubing should not be on the floor.</p> <p>A current facility policy "Catheter Care, Urinary", with a revision date of October 2010 and provided by the Director of Nursing on 11/21/14 at 9:14 a.m., indicated "...The purpose of this procedure is to prevent catheter-associated urinary tract infections...Check the resident frequently...to keep the catheter and tubing free of kinks...Be sure the catheter tubing and drainage bag are kept off the floor...."</p> <p>3.1-41(a)(2)</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.</p> <p>A. Based on interview and record review, the facility failed to ensure a resident with recent, repeated falls, was provided adequate supervision to prevent falls for 1 of 2 residents reviewed for falls. (Resident #104)</p> <p>B. Based on observation, interview and record review, the facility failed to ensure the Instant Hand Sanitizer with Aloe, Super Sani-Cloth germicidal disposable wipes, alcohol prep pads and bottles of hydrogen peroxide (16 and 4 ounce) were secured and out of reach confused and mobile residents who resided in the facility. This deficient practice had the potential to affect 18 confused and mobile residents of the 124 residents who resided in the facility.</p> <p>Findings include:</p> <p>A. On 11/19/14 at 10 a.m. the clinical record of Resident #104 was reviewed.</p>	F000323	Resident # 104 care plan and fall interventions have been reviewed for appropriateness. Residents who have had a past fall has had their plan of care reviewed to ensure adequate supervision is being provided. The facility has removed Instant Hand Sanitizer with Aloe, Super Sani-Cloth germicidal disposable wipes, alcohol prep pads and bottles of hydrogen peroxide from confused and mobile residents reach. Nursing staff will be educated on interventions to manage resident falls and storage of the above chemicals by December 19th 2014. The Clinical Directors or designee will audit random residents' post fall interventions and storage of chemicals three times a week for 30 days, weekly for 2 months, and monthly for 3 months with audit findings brought to monthly quality assurance meeting.	12/21/2014

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	<p>Diagnoses included, but were not limited to, the following: personal history of falls, anxiety state dementia and scoliosis. The MDS (minimum data set) assessment dated 8/2/14 included but was not limited to, the following: severely impaired cognition and transfers required extensive assistance.</p> <p>A plan of care, with a revision date of 9/22/14, had the following focus: "...has had recent falls due to her history of falls, high risk meds (medications), incontinence of bladder." Interventions included, but were not limited to, the following: "bed against wall, bed bolster to mattress, matt at bedside, pressure alarm at all times, sensor pad under shoulders."</p> <p>On 11/21/14 at 9:16 a.m. the 400 Unit Manager (UM) was interviewed regarding the following clinical record interdisciplinary notes:</p> <p>An Interdisciplinary note on 9/11/14 at 4:15 p.m. "alarm sounding...Res (resident) laying on floor mat...no apparent injury...current interventions...bed in lowest lock position, pressure alarms, check resident every hour...New intervention: bed against wall...Medication Review Requested: yes; completed: yes..." A</p>			

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	<p>"Rehabilitation Post-Fall Screening" form dated 9/13/14 indicated the following: "Recommended Change...place pull tab alarm on opposite shoulder of which she rolled out of bed..." At the time, the UM indicated he was unsure if this had been implemented as loud noises agitated the resident.</p> <p>An Interdisciplinary note on 9/13/14 at 4:45 p.m. "...heard (resident name) yell out, went to see her...found her kneeling at her bedside. No injuries...Current Interventions...assess...every hour...pressure alarms...New interventions:...sensor pad placed under shoulders...Medication review requested: yes; completed: yes." At the time, the UM was unable to tell from this documentation if the resident's alarm had been sounding or not.</p> <p>An Interdisciplinary note on 9/19/14 at 2:10 p.m. "Resident slid out of bed...injuries none; current interventions:...pressure alarm...New intervention: regular mattress with bed bolster cover...Medication review requested: yes; completed: yes." At the time, the UM was unable to tell from this documentation if the resident's alarm had been sounding or not.</p> <p>An Interdisciplinary note dated 10/27/14</p>			

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	<p>at 2:20 p.m. indicated the following: "Resident slid off side of bed while sitting on side of bed...injury: none...current interventions: bed bolsters, pressure alarms, sensor pad...New intervention: med (medication) review...medication review requested: yes; completed: yes..." A Fall Accident Report, dated 10/27/14 at 2:20 p.m. indicated the bed alarm had been sounding; and the conclusion and summary included: "res (resident) med review sent, staff noted generic Lexapro was being sent from pharmacy again - she is to only have brand name..."</p> <p>An Interdisciplinary note dated 10/27/14 at 9:30 p.m. indicated the following: "...observed lying on floor mat next to bed...injury: none; current interventions: alarms...bed bolsters...New intervention: sent to hospital...medication review requested: yes; completed: yes..." The UM indicated at the time, the resident was sent to the hospital because she was shaking and was very combative with care. The Fall Accident Report, dated 10/27/14 at 9:30 p.m. indicated the following: the alarm was sounding; "has there been a change in mental status: Patient began yelling and screaming at patient's wall..."</p> <p>On 11/21/14 at 9:16 a.m. the UM was</p>			

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	<p>interviewed. He indicated the reason the door to the resident's room was always closed was because the resident's roommate liked to keep the door closed because she (the roommate) thought it kept the heat in the room.</p> <p>On 11/21/14 at 10:08 a.m. the DON (Director of Nursing) was interviewed. She indicated the fall alarm was able to be heard from the resident's room even with the door closed. She indicated the new intervention for the 10/27/14 fall of the med review involved the following: on 10/27/14 at 2:20 p.m. the pharmacy was faxed a list of the resident's current medications. She indicated depending on what time the list is faxed to the pharmacy, they may get a reply from the pharmacy as soon as a few hours. At the time, the "Consultant Pharmacist-MD (medical doctor) communication" form was reviewed. This form was dated 10/29/14 with the following information: "Also noted that pharmacy has been recently provided generic, has order for brand name Lexapro (antidepressant) r/t (related to) increased anxiousness. Pharmacy fixed issue with generic vs (versus) brand name."</p> <p>On 11/21/14 at 11 a.m. the current physician orders were reviewed. They included but were not limited to, the</p>			

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	<p>following: "Name brand Lexapro only d/t (due to) hallucinations." This order was dated 6/5/2013. At the time, the medication administration record (MAR) for September 2014 and October 2014 were reviewed. This form indicated the following: "Lexapro...depression and anxiety...do not substitute."</p> <p>On 11/21/14 at 11:40 a.m. the UM provided copies of the Fall Accident Reports dated 9/13/14 and 9/19/14. Both of these reports indicated the bed alarms had been sounding at the time the resident had fallen. The report dated 9/13/14 at 4:45 p.m. indicated "has there been a change in mental status: Describe: increase agitation." The report dated 9/19/14 at 2:10 p.m. indicated "has there been a change in mental status? Describe: increase anxiety..."</p> <p>On 11/21/14 at 2:30 p.m. the DON provided a current copy of the facility policy and procedure for "Falls - clinical protocol" dated October 2010. This policy included, but was not limited to, the following: "...The staff will evaluate and document falls that occur while the individual is in the facility...For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall...the staff and physician will monitor and document the</p>			

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	<p>individual's response to interventions intended to reduce falling or the consequences of falling...If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions..."</p> <p>On 11/21/14 at 2:38 p.m. the 400 Hall Unit Manager (UM) was interviewed. He indicated as a result of the investigation by the facility, they felt the fact the resident had received the generic brand of the medication Lexapro caused her to have an increase in agitation and/or behaviors which contributed to her falls as she had a cluster of falls in September and October. The UM indicated after they stopped the resident's generic Lexapro, within about 4-5 days, the resident had calmed down and was back to acting like herself. The UM indicated this same thing happened in June of 2013 when they changed the resident initially to the generic brand of Lexapro. The UM indicated this was why they got the physician order to only give the resident the brand name form of the Lexapro.</p> <p>On 11/21/14 at 4:16 p.m. the DON was interviewed. At the time, she also</p>			

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	<p>provided copies of the nursing report sheets for the dates of 10/27/14 and 10/28/14. For Resident #104, the form included, but was not limited to, the following for the 6 a.m. - 6 p.m. shift on 10/27/14: "one on one post fall." At the time, the DON indicated she was unaware how long the resident was on the one on one intervention. The nursing report sheet for 10/27/14 6 p.m. to 10/28/14 6 a.m. lacked documentation of the resident being on one to one observation. A note indicated "fell out of bed at 3 p.m." The nurse report sheet dated 10/28/14 indicated the following: "fall follow up - hallucinating, hitting, biting, screaming, sent to (name of hospital), sent back..."</p> <p>On 11/21/14 at 4:40 p.m. the nurses notes for 10/27/14 and 10/28/14 were reviewed. Documentation was lacking of the resident having had one to one observation.</p> <p>B. An observation on 11-16-2014 at 4:05 p.m., indicated a bottle of Instant Hand Sanitizer was out on the counter at the nurse's station in the 400 hall and accessible to residents.</p> <p>An observation on 11-16-2014 at 4:40 p.m., indicated an open box of 6 - 16 ounce bottles of hydrogen peroxide and</p>			

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	<p>15 - 4 ounce bottles of hydrogen peroxide were on the counter at the nurse's station in the Rehabilitation unit and within reach of residents.</p> <p>An observation on 11-19-2014 at 9:42 a.m., indicated a bottle of Instant Hand Sanitizer was on the nurse's station desk at the entrance near the conference room in the Rehabilitation unit. A resident with a walker was observed to enter the nurse's station behind the counter.</p> <p>An observation on 11-19-2014 at 9:53 a.m., indicated of a box of alcohol prep pads were on the unattended counter across from the Director of Nursing's (DON) office which was accessible to residents. One resident was observed in the area watching television.</p> <p>An observation on 11-19-2014 at 9:54 a.m., indicated a container of Instant Hand Sanitizer was behind the nurse's station in the 200/300 hall. One resident was observed sitting across from the nurse's station in a wheelchair.</p> <p>An observation on 11-19-2014 at 9:57 a.m., indicated 2 containers of Super Sani-Cloths and a bottle of Instant Hand Sanitizer were on the counter at the 100 hall nurse's station. One resident was sitting at the nurse's station in a</p>			

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	<p>wheelchair.</p> <p>An observation on 11-19-2014 at 10:21 a.m. and at 10:35 a.m., indicated a bottle of Instant Hand Sanitizer with a label Warning "Keep out of Reach of Children" was left unattended on a medication cart outside a resident's room in the 400 hall.</p> <p>An observation on 11-19-2014 at 11:11 a.m., indicated a box of alcohol prep pads were unattended and accessible to residents on the counter across from the DON's office.</p> <p>An observation on 11-19-2014 at 11:16 a.m., indicated the unattended 200/300 nurse's station had a bottle of Instant Hand Sanitizer on the back counter and 2 residents were sitting across from the station in wheelchairs.</p> <p>An observation on 11-19-2014 at 11:18 a.m., indicated a Resident had a bedside table in his area of the room with the following products out on top of the table: Hydrogen Peroxide 16 ounce bottle (label indicated "...external use only...Keep out of Reach of Children...." Alcohol Prep Pads Instant Hand Sanitizer</p>			

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	<p>An observation on 11-19-2014 at 11:45 a.m., indicated the 100 hall nurse's station was unattended and 2 containers of Super Sani-Cloths and 1 bottle of Instant Hand Sanitizer were on the nurse's station counter. Four residents in wheelchairs were observed sitting a few feet down the hall from the nurse's station.</p> <p>An observation on 11-19-2014 at 4:25 p.m., indicated a nurse spilled medications on the floor in the 300 hall. Further observation at 4:35 p.m. indicated 1 white oblong pill was in the trash can in a spoon with applesauce. The trash can was located on the side of the medication cart in the 300 hall.</p> <p>An interview with LPN #10 on 11-19-2014 at 4:37 p.m., indicated there was a resident who likes to snoop thru the trash, so she closed the trash can lid, but the lid was able to be opened.</p> <p>An observation on 11-19-2014 at 4:30 p.m., indicated a box of alcohol prep pads were on the unattended counter across from the DON's office.</p> <p>An observation on 11-20-2014 at 8:55 a.m., indicated an alcohol prep pad was left out on top of the unattended 300 hall medication cart.</p>			

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	<p>An observation on 11-20-2014 at 9:55 a.m., indicated a box of alcohol prep pads were left out on the unattended counter across from the DON's office.</p> <p>An observation on 11-20-2014 at 10:22 a.m., indicated a container of Super Sani-Cloths was at the 100 hall nurse's station with staff coming and going from the nursing station. Three residents were observed sitting in lounge right near the 100 hall nurses station.</p> <p>An interview with LPN #32 on 11-20-2014 at 8:55 a.m., indicated discontinued medications that were unable to be returned were to be discarded in the sharps container.</p> <p>An interview with LPN #28 on 11-20-2014 at 9:35 a.m., indicated medication that had been discontinued and was included in the medication packet with the current medications, should be discarded in the sharps container.</p> <p>An interview with the Administrator, Director of Nursing (DON) and Quality Assurance Manager on 11-20-2014 at 3:10 p.m., indicated medical/personal items for residents should be stored in a drawer in their room, Super Sani-Cloths and alcohol prep pads were usually stored</p>			

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	<p>in the medication carts, Instant Hand Sanitizer should be stored in a staff pocket or in the medication cart and discarded medications should be placed in the sharps container on the medication cart and not in the trash.</p> <p>A copy of the Instant Hand Sanitizer label provided by the DON on 11-21-2014 at 8:00 a.m., indicated "...warnings...for external use only...keep out of reach of children...."</p> <p>A copy of the Super Sani-Cloth label provided by the DON on 11-21-2014 at 8:00 a.m., indicated "...not a skin wipe...keep out of reach of children.</p> <p>A copy of the Material Safety Data Sheet (MSDS) for Super Sani-Cloth dated 8-12-2012 and provided by the DON on 11-21-2014 at 8:00 a.m., indicated "...Danger...causes irreversible eye damage...do not get in eyes or on clothing...avoid contact with skin...."</p> <p>A copy of the alcohol prep pad label provided by the DON on 11-21-2014 at 8:00 a.m., indicated "...Warnings...keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>A copy of the hydrogen peroxide label</p>			

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	<p>provided by the DON on 11-21-2014 at 8:00 a.m., indicated "...Warnings...keep out of reach of children...."</p> <p>A copy of the MSDS for hydrogen peroxide dated 6-4-2013 and provided by the DON on 11-21-2014 at 8:00 a.m., indicated "...if swallowed, get medical help or contact a poison control center right away...."</p> <p>An interview with the DON on 11-21-2014 at 1:00 p.m., indicated there were 18 confused and mobile residents in the facility.</p> <p>A policy "Medication Storage" dated June 2014 and provided by the DON on 11-21-2014 at 1:00 p.m., indicated "...poisons or chemicals such as cleaning fluids and detergents, which are not for human consumption...must...be stored under proper security so as to prevent individual residents from gaining access to them...."</p> <p>3.1-45(a)(2) 3.1-45(a)(1)</p>			

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law,</p>			

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	<p>whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure the nurse staff posting was accurate and contained the number of hours worked for the licensed staff. This deficiency had the potential to affect all 124 residents who resided in the facility.</p> <p>Findings include:</p> <p>An observation of the "Daily Nurse Staffing Form" located at the receptionist desk on 11-16-2014 at 4:05 p.m., indicated the following staff numbers for the 2:p.m. - 10:00 p.m. shift:</p> <p>7 Registered Nurses (RN) 6 Licensed Practical Nurses (LPN) 1 Qualified Medical Assistants (QMA) 13 Certified Nursing Assistants (CNA) There were no hours listed for each discipline during each shift.</p> <p>During the initial tour on 11-16-2014 at 4:05 p.m., the total staff numbers on duty were:</p> <p>3 RNs (RN#18, #8 and #19) 5 LPNs (#28, #29, #30, #10 and #31) 12 CNAs (#20, #21, #22, #23, #24, #2, #25, #6, #9, #26, #27, and #3) 0 QMA</p> <p>On 11-16-2014 at 6:48 p.m., a review of the staff schedule for 11-16-2014 was</p>	F000356	<p>The nurse staff posting was corrected to include number of hours with the posted number of staff on 11-16-14. Training was completed on 11-20-14 with staff members assigned to complete the nurse staff posting. Daily audits began on 11-17-14 and continued through 11-28-14 by the Director of Nursing. Random audits will continue weekly for 4 weeks and monthly for 5 months by the Director of Nursing or designee. Findings of audits will be discussed monthly in the facilities quality assurance meeting with follow up education completed as needed.</p>	11/21/2014

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	<p>provided by the Administrator. The schedule indicated the 400 hall first shift nurses (3 LPNs) were scheduled to work 6 a.m. to 6 p.m., with 1 RN working from 6 p.m. to 10 p.m. QMA #23 was written in under the 2nd shift for 100 hall. The balance of the staff were identified during the initial tour.</p> <p>An interview with the Administrator and the Director of Nursing (DON) on 11-16-2014 at 6:50 p.m., indicated the new receptionist was responsible for filling out the "Daily Nurse Staffing Form" and the Administrator and DON indicated the form was not correct. The DON indicated the Daily Nurse Staffing Form numbers were "listed by license held, not the job the nursing staff were doing." The QMA #23 was to be a QMA from 6 p.m. to 10 p.m., but was fulfilling CNA duties from 2 p.m. to 6 p.m. The DON indicated there were 5 RNs present during the evening shift.</p> <p>An interview with the DON on 11-17-2014 at 9:11 a.m., indicated there were only 4 RNs present during the evening shift, not the 5 RNs on the staffing form. Further interview with the DON indicated the facility had not ever entered the number of hours each discipline worked during each shift.</p>			

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	<p>An interview with the DON on 11-17-2014 at 9:37 a.m., indicated the Clinical Directors and the MDS (Minimum Data Set) Coordinators were included on the Nurse Staffing Form. Further interview with the DON indicated the MDS Coordinator was not responsible for patient care and the Clinical Directors were not assigned residents, but do answer call lights, do wound rounds and assist with resident care.</p> <p>An observation on 11-17-2014 at 12:15 p.m., indicated the Daily Nurse Staffing Form on the receptionist desk listed the numbers by discipline and shift, without hours worked.</p> <p>A review of the Daily Nurse Staffing Forms for 11-10-2014 through 11-15-2014 provided by the DON on 11-17-2014 at 3:45 p.m., indicated the number of hours for each discipline were not listed on the form.</p> <p>A current policy "Posting of Nurse Staffing Information" dated 5/2009 and provided by the DON on 11-21-2014 at 4:34 p.m., indicated "Skilled Nursing Facilities and Nursing Facilities are required to post, on a daily basis, the actual hours of and total number of hours worked by licensed and unlicensed</p>			

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F000371 SS=F	nursing staff who are directly responsible for resident care on each shift in the facility...." 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 A. Based on observation, interview and record review the facility failed to maintain a clean and sanitary kitchen and service kitchen as evidenced by: dirty floors and equipment, foods and utensils not protected from potential contamination, and the lack of thermometers in coolers and freezers. The facility also failed to ensure staff washed their hands at the appropriate time for the recommended amount of time, and failed to prevent staff from	F000371	The kitchen and service kitchen have been cleaned and thermometers are present in coolers and freezers. Food located in the coolers and freezers is dated and stored appropriately. The snack refrigerators located in medication rooms have been checked for undated and unlabeled food. Dietary staff has created a cleaning schedule. Staff will be educated on the cleaning procedures in the main and service kitchens and food dating and storage in the coolers and freezers by December	12/21/2014	

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	<p>handling food with their bare hands. This deficient practice had the potential to affect 120 of 124 residents who ate meals prepared by the facility.</p> <p>B. The facility failed to keep the snack and beverage refrigerator in 1 of 3 medication rooms observed, free from unlabeled and non-dated food and beverages, potentially affecting 37 residents who received food or beverages from the refrigerator.</p> <p>Findings include:</p> <p>1. During an initial tour of the facility kitchen on 11/16/14, the following was observed:</p> <p>- The floors of the service area of the kitchen, the dry storage area, and the dishroom area were littered with paper, a drinking glass, a fruit bowl, paper clips, and a hair restraint. Crumbs of food and a white powdered substance were observed on the floor, around the legs of equipment, and along the baseboards. Dried dirt and debris were observed caked around the legs of equipment and shelving units, as well as along the baseboards and corners of the kitchen. Dried food and debris were also observed on the ramps leading into the walk-in cooler and walk-in freezer as well as on</p>		<p>19th 2014. Staff will be educated on appropriate times for and appropriate length of hand washing when assisting resident in the dining rooms, the appropriate way to assist with meal set up without touching bare hands to food, and appropriate food storage labeling and dating procedures for medication room refrigerators by December 19th 2014. The Dietary manager will audit the main and service kitchen for cleanliness three times a week at random times for 30 days, weekly for 2 months, and monthly for 3 months. The Clinical Directors will audit hand washing and food set up in the dining rooms and food storage in the medication room refrigerators three times a week for 30 days, weekly for 2 months, and monthly for 3 months. Findings of audits will be discussed monthly in the facilities quality assurance meeting.</p>	

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	<p>the floor of the units.</p> <ul style="list-style-type: none"> - The outside of the microwave oven, including the handle, was extremely dirty with dried spills and food. - Thermometers could not be located in the reach-in milk cooler and in the walk-in freezer. - A pan of orange gelatin with shredded carrots was observed in the walk-in cooler, not covered, labeled, or dated. - Four large sheet pans containing torn-up pieces of bread were observed on an open shelving unit in the kitchen. Cook #5 was interviewed at 4:12 p.m. During the interview she indicated the bread was to be used for bread pudding served later in the week. - Shelves under the cooking preparation table, which held pots, pans and baking sheets, were observed to be soiled with food crumbs and debris. <p>2. During an observation of the satellite kitchen attached to the Crown Dining Room on 11/16/14 at 4:18 p.m., the inside of the microwave oven was observed to be soiled with food debris and spills.</p>			

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	<p>3. During an observation of the dinner meal on 11/16/14 in the Royal Cafe Dining Room, the following was observed;</p> <ul style="list-style-type: none"> - At 5:35 p.m., Certified Nursing Assistant (CNA) #6 was observed to wash her hands for 6 seconds prior to serving a meal tray to a resident. - At 5:38 p.m., CNA #7 was observed to place soap on her hands and immediately lather her hands for 12 seconds under running water. She was then observed to serve a meal tray to a resident. - At 5:42 p.m., CNA #7 was observed to place soap on her hands and immediately lather her hands for 16 seconds under running water. She was then observed to serve a meal tray to a resident. - At 5:46 p.m., CNA #7 was observed to place soap on her hands and immediately lather her hands for 20 seconds under running water. She was then observed to serve a meal tray to a resident. - At 5:47 p.m., RN #1 was observed to lather his hands for 8 seconds prior to rinsing. He was then observed to serve a meal tray to a resident. - At 5:48 p.m., RN #8 was observed to 			

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	<p>lather her hands for 16 seconds prior to rinsing. She was then observed to serve a meal tray to a resident.</p> <p>- At 5:49 p.m., CNA #9 was observed to lather her hands for 15 seconds prior to rinsing. She was then observed to serve a meal tray to a resident.</p> <p>- At 5:52 p.m., CNA #3 was observed to lather her hands for 12 seconds prior to rinsing. She was then observed to serve a meal tray to a resident.</p> <p>- At 5:55 p.m., RN #1 was observed to lather his hands for 16 seconds prior to rinsing. He then was observed to speak with a resident seated at a dining room table, touching her sweater with his hands. He then picked up a clean clothing protector and placed it on the resident.</p> <p>- At 6:01 p.m., LPN #10 was observed to lather her hands for 16 seconds prior to rinsing. She then was observed to serve a meal tray to a resident.</p> <p>4. During an observation of the lunch meal on 11/17/14 in the Royal Cafe Dining Room, the following was observed:</p> <p>- At 12:17 p.m., CNA #11 was observed</p>			

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	<p>to lather her hands for 6 seconds prior to rinsing. She was then observed to serve a meal tray to a resident.</p> <p>- At 12:18 p.m., CNA #12 was observed seated at a table feeding a resident. She was observed to get up from the table to encourage another resident at a different table to eat by touching the resident's arm. She then was observed to return to the first resident and resume feeding the lunch meal. She was not observed to wash her hands.</p> <p>- At 12:21 p.m., CNA #13 was observed to place soap on her hands and immediately place her hands under the running water. She was then observed to serve a meal tray to a resident.</p> <p>- At 12:25 p.m., CNA #14 was observed to place soap on her hands and immediately place her hands under the running water. She was then observed to serve a meal tray to a resident.</p> <p>5. During an observation of the lunch meal on 11/19/14 in the Royal Cafe Dining Room, the following was observed:</p> <p>- At 12:08 p.m., CNA #15 was observed to pick up a slice of buttered bread with her bare hands and place it on the plate of</p>			

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	<p>a resident.</p> <p>- At 12:10 p.m., CNA #16 was observed to remove a slice of bread from the wrapper with her bare hands.</p> <p>6. During an observation of the satellite service kitchen on 11/20/14 at 10:43 a.m., the following was observed:</p> <p>- The inside of the microwave oven was observed to be soiled with food debris and spills.</p> <p>- The trash container was observed to be uncovered and not in use.</p> <p>- A clear plastic bin on a shelf under the steam table, containing serving utensils, was observed to be soiled with food crumbs and dust. The bin was not covered.</p> <p>- An open shelf on a cart under the service window was observed to hold 2 serving trays. Nine loaves of bread, 1 package of dinner rolls, 1 package of hamburger buns, and 1 bag of potato chips were observed on the service trays. The shelf containing the bread products and potato chips was only 2 inches above the floor.</p> <p>Weekly cleaning schedules for the</p>			

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	<p>kitchen and the satellite service kitchen were provided by the Certified Dietary Manager (CDM) on 11/20/14 at 9:27 a.m. The cleaning schedules described what areas were to be cleaned each shift of each day. The most recent cleaning schedules found by the CDM were dated 10/9/14, 10/16/14, and 10/22/14. Not all areas assigned to be cleaned on those days were done by staff as they did not contain staff initials to indicate their completion. There were no cleaning schedules for the month of November, 2014, available for review.</p> <p>The CDM was interviewed on 11/20/14 at 1:40 p.m. During the interview he indicated cleaning schedules were to be followed, thermometers were to be in any refrigerator and freezer, food was to be covered, labeled and dated, and food products were to be at least elevated 6 inches above the floor. He also indicated staff were to lather their hands for 20 seconds and were to wash their hands after touching anything soiled. He further indicated staff were not to touch any food with bare hands.</p> <p>A current facility policy "Dietary Infection Control", with a revision date of April 2005 and provided by the CDM on 11/20/14 at 4:26 p.m., indicated "...All local, state, and federal standards and</p>			

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	<p>regulations are followed in order to assure a safe and sanitary dietary department...All staff...will handle all foods safely...All staff are to wash their hands just before they start to work...and when they have used their hands in an unsanitary way such as...handling residents...Food that is stored is protected from contamination and growth of any pathogenic organisms...Among the food protection measures that are performed by the dietary department are: Foods that are refrigerated are stored at or below 40 degrees F (Fahrenheit)...Foods are protected from dust, flies, rodents, and other vermin...The foods that are stored in the stockroom are placed on clean racks at least 6 inches above the floor. The room is clean, dry, and cool...All leftovers are labeled, covered, and dated when stored...."</p> <p>A current facility policy "Hand Washing", with a revision date of April 2005 and provided by the CDM on 11/20/14 at 4:26 p.m., indicated "...Wet hands and forearms with warm water and apply an antibacterial soap...Scrub well with soap and additional water as needed, scrubbing all areas thoroughly...Wash for minimum of 10-10 seconds...."</p> <p>7. During an observation of the dinner meal tray service on 11/16/14 at 5:50 p.m., CNA #3 delivered a meal tray to a</p>			

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	<p>Resident's room on the 200 Hall. The CNA returned to the Royal Cafe Dining Room, where she washed her hands with soap and water, lathered her hands for 10 seconds before rinsing them with water. The CNA indicated she was going to feed a Resident in their room.</p> <p>B1. During an observation of the Resident's snack and beverage refrigerator in the 200/300 hall Medication room with Nurse #32 on 11/21/13 at 9:50 a.m. the following was observed:</p> <p>At 9:52 a.m., a sandwich in a plastic zip lock bag was in the refrigerator. The plastic bag was not labeled with a name or a date.</p> <p>At 9:52 a.m., a glass container with green beans was covered with a plastic lid. The container of green beans was not labeled with a name or a date.</p> <p>At 9::52 a.m., a glass container with pasta was covered with a plastic lid. The container of pasta was not labeled with a name or a date.</p> <p>At 9:54 a.m., a plastic container with a milky liquid was in the door of the refrigerator. The container was not labeled with a name or a date.</p>			

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	<p>An interview with Nurse #32 on 11/21/14 at 9:55 a.m., indicated the container in the door of the refrigerator appeared to be breast milk. She indicated the machine on top of the countertop was a breast pump. She indicated the breast milk should have been stored in the employee's refrigerator in the employee lounge. She also indicated she could not determine who the sandwich, green beans and pasta belonged to or how long they had been in the refrigerator.</p> <p>This deficiency was cited on the annual Recertification survey on December 12, 2013 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-21(i)(1) 3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000431 SS=E	<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</p>			

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	<p>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 medication carts were clean, over the counter medications were labeled with resident names, expired medications/supplies were removed from the medication carts/rooms and open dates were recorded on multi use medications for 7 of 8 medication carts and 1 of 3 medication rooms in the facility.</p> <p>Findings include:</p> <p>1. An observation of the 100 hall medication cart with RN #18 on</p>	F000431	<p>Medications carts have been cleaned, OTC medications have been labeled with correct information. Medication carts have been audited for expired medications and for appropriate dates. A medication cart cleaning schedule and audit has been created to ensure cleanliness of the cart, that medications have been labeled, dated and that no expired medications are in the cart. Nursing staff will be educated by Dec 19th 2014 on proper medication labeling, expired medications, medication cart cleaning and the medication cart audit documentation. The Clinical Directors or designee will audit medication carts weekly for 2 months, and monthly for 4 months with audit findings</p>	12/21/2014

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	<p>11-21-2014 at 9:20 a.m., indicated an over the counter bottle of acetaminophen 325 mg (milligram) tablets and ferrous sulfate 325 mg tablets did not have a resident name written on the bottles. A bottle of Robitussin DM with an open date of 9-30-2014 was in the bottom drawer of the 100 hall medication cart and did not have a resident name on the bottle.</p> <p>An interview with RN #18 on 11-20-2014 at 9:21 a.m., indicated she was able to identify the resident who had the acetaminophen and ferrous sulfate, but was unable identify which resident the Robitussin DM belonged. RN #18 was unsure of the cleaning schedule for the medication carts.</p> <p>An observation of the 100 hall medication storage room with RN #18 on 11-21-2014 at 9:25 a.m., indicated 4 cans of Jevity 1.2 on the shelf with an expiration date of December 2013. In the medication overflow cabinet, there was an opened container of hydrogen peroxide and Fiber Caps without a label identifying the name of the resident who the medications belonged.</p> <p>An interview with RN #18 on 11-21-2014 at 9:27 a.m., indicated she did not know which resident the</p>		brought monthly to the facility quality assurance meeting.	

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	<p>hydrogen peroxide or Fiber Capsule belonged.</p> <p>2. An observation of medication cart 200 B with LPN #38 on 11-21-2014 at 9:40 a.m., indicated the bottom drawer had a caked white substance that was adhered to the bottom surface of the drawer.</p> <p>An interview with LPN #38 on 11-21-2014 at 9:41 a.m., indicated she was unsure of the cleaning schedule for the medication carts.</p> <p>3. An observation of the 400 B medication cart with LPN #39 on 11-21-2014 at 9:45 a.m., indicated 1 loose pill was observed in the 2nd drawer of the cart.</p> <p>An interview with LPN #39 on 11-21-2014 at 9:46 a.m., indicated for residents that have over the counter medications brought in by family, the resident's name needed to be on the container. The LPN further indicated she was unsure of the cleaning schedule for the medication carts.</p> <p>4. An interview with LPN #28 on 11-21-2014 at 9:50 a.m., indicated she was not sure of the cleaning schedule for the medication cart.</p>			

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	<p>An observation of the 400 A medication cart with LPN #30 on 11-21-2014 at 10:00 a.m., indicated 1 loose pill in the top drawer and a white, gritty substance noted in corners and on the bottom drawer of the medication cart.</p> <p>An interview with RN #1 on 11-21-2014 at 10:04 a.m., indicated third shift cleans the medication and treatment carts as needed. RN #1 indicated there was not documentation of the medication/treatment cart cleaning. Further interview with RN #1, indicated the "cleaning" was to check for medications for discharged residents, for expired medications, to check for insulin and eye drop open dates and the medication and treatment carts were cleaned "as needed."</p> <p>5. An observation of the 200 B medication cart (for rooms 215 - 230) with LPN #40 on 11-21-2014 at 10:30 a.m., indicated the bottom drawer had a white, gritty debris on the bottom surface and corners in the bottom drawer of the medication cart drawer.</p> <p>6. During an observation of the 300 Hall medication cart with Nurse #32 on 11/21/14 at 9:40 a.m., multi-colored powder and small pieces of pills were in the bottom corners of the drawers of the medication cart.</p>			

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	<p>During an interview with Nurse #32 on 11/21/14 at 9:45 a.m., she indicated she was not aware of who was responsible to clean the medication carts.</p> <p>7. During an observation of the Back 200 Hall Medication cart with Nurse #19 on 11/22/14 at 10:00 a.m., the following was observed:</p> <p>-Nystatin Cream was in the top drawer of the medication cart. The Nystatin Cream was not labeled with a name or a room number. The medication appeared to be opened and used. Nurse #19 indicated she was not sure who the Nystatin Cream belonged too and indicated she had never seen the tube of medication before and indicated a family must have brought it in to the facility.</p> <p>-Poly-Iron (a supplement) 150 an OTC (Over-the-Counter) was opened and was not labeled with a name only 2 initials were on top of the bottle's cap. The physician's name was not labeled on the bottle.</p> <p>-Vitamin C 500 (an OTC supplement) was opened and was not labeled with a name only 2 initials were on top of the bottle's cap. The physician's name was not labeled on the bottle.</p>				

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	<p>-Fluticasone Nasal Spray (treatment of rhinitis) was in a plastic bag, and it was opened but did not have an opened date labeled on the bottle or the plastic bag.</p> <p>-An OTC bottle of Acetaminophen (for pain and fever) 500 mg was without a resident's name or physician's name labeled on the bottle.</p> <p>-An OTC bottle of PreserVision Eye Vitamin (a supplement) was without a resident's name or physician's name labeled on the bottle.</p> <p>-Humulin R Insulin was labeled with an open date of 8/26/14. Nurse #19 indicated the bottle of insulin should not have been in the medication cart because it was expired. She indicated the resident no longer received Humulin R Insulin. She indicated there was information at the Nurse's Station to determine when the insulin expires after it was opened.</p> <p>-Vigamox 0.5% Eye Drops (for dry eyes) was opened without an open date labeled on the bottle.</p> <p>-An OTC bottle of Acetaminophen 500 mg was without a resident's name or physician's name labeled on the bottle</p>			

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	<p>-Proair HAF Inhaler was opened without an opened date on the inhaler or the plastic bag containing the Rx (prescription) information.</p> <p>-An OTC bottle of LiquiTears (for dry eyes) was opened without an opened date on the label.</p> <p>-An OTC bottle of Tylenol (for pain and fever) 325 mg was opened without a resident's name or physician's name labeled on the bottle.</p> <p>-An OTC bottle of Tylenol 500 mg was opened without a resident's name or physician's name labeled on the bottle.</p> <p>-Humalog Insulin was labeled with an open date of 9/17/14. Nurse #19 indicated she was not sure if the resident was still receiving Humalog Insulin. She removed the Insulin from the medication cart.</p> <p>-Lantus Insulin was labeled with an open date of 10/5/14. Nurse #19 removed the Lantus Insulin from the medication cart.</p> <p>-1 loose un-identified pill was in the drawer of the medication cart. Nurse# 19 removed the pill and disposed of the pill in the sharps container on the side of the medication cart.</p>			

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	<p>During an observation of the Back 200 Hall Medication the bottom of the drawers had multicolored pill powder and pieces of pills in the corners of the drawers.</p> <p>An interview with Nurse #19 on 11/21/13 at 10:25 a.m., she indicated the medication carts were cleaned regularly. She also indicated she did not know how often the medication carts were cleaned and did not know who was responsible to clean the medication carts.</p> <p>On 11/21/14 at 4:35 p.m., the DON provided the Facility's current policy "Insulin Administration", with a revision date of October 2010, which indicated the following, "...Check for expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiring after opening)...."</p> <p>On 11/21/14 at 4:40 p.m., a review of the Internet site, Rxlist.com, indicated the following, "...In-use (opened): Humulin R Insulin U-100 bottle you are currently using can be kept un-refrigerated as long as it is kept as cool as possible...away from heat and light. In-use bottles must</p>			

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	<p>be used within 31 day or be thrown out, even if they still contain Humulin R Insulin...."</p> <p>On 11/21/14 at 4:45 p.m. a review if the Internet site, Humalog.com, indicated the following, "...After first use (opened), store vial in the refrigerator or if necessary, at room temperature...Throw away opened vials 28 days after first use, even if there is insulin left in the vial...."</p> <p>On 11/21/14 at 4:40 p.m., a review of the Internet site, Lantus.com on 11/21/14 at 11:00 a.m. indicated the following, "...After 28 days, throw your open Lantus away even if it still has insulin in it...."</p> <p>A current policy "Labeling of Medication Containers" dated April 2007 and provided by the DON (Director of Nursing) on 11-21-2014 at 2:20 p.m., indicated "...labels for over-the-counter drugs shall included all necessary information, such as...the resident's name...."</p> <p>An interview with the DON on 11-21-2014 at 2:51 p.m., indicated the facility did not have a policy for the medication/treatment cart cleaning.</p> <p>3.1-25(1)(1)(2) 3.1-25(j)</p>			

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F000520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will</p>			

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	<p>not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility QAA (Quality Assurance Committee) failed to implement an adequate action plan for the identified concerns which included the following: not ensuring the dignity of residents during dining, not providing activities for cognitive impaired residents, not ensuring the safety of residents, not following Physician Orders, not keeping Foley catheter tubing off the floor, not providing clean kitchens and not protecting food from contamination, not monitoring refrigerator and freezer temperatures and not storing foods in refrigerators with adequate labeling, not keeping the medication and treatment carts clean, not labeling over-the-counter medications adequately, not keeping medication carts/rooms free of expired treatment medication, and inadequate handwashing during meal services. These deficiencies had the potential to affect 124 of 124 Resident who reside at the facility.</p> <p>Findings include:</p> <p>An interview with the DON on 11/21/14 at 4:00 p.m., indicated the QAA committee was aware of some of the identified concerns. She indicated the</p>	F000520	The facility quality assurance committee meetings are held monthly and will include the findings of the facilities 2014 annual survey results and a review of the plan of correction and audit findings. Within each department auditing will occur to recognize deficiencies that are present and will be brought forward to quality assurance for root cause analysis and action planning for correction. Facility staff will be educated on bringing concerns forward for quality assurance committee review and items currently being addressed by the committee by December 19th 2014. The Administrator or designee will audit the quality assurance committee agenda and meeting agenda monthly for 6 months.	12/21/2014

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	<p>QAA have been focused on customer service, such as food and dining services, menus, and food temperatures. She indicated the committee has developed and monitored laundry services and labeling clothing better and have reduced missing items. She also indicated they had on going monitoring of call lights, falls, safety of the Residents, pain management and infections. She indicated they have had ongoing education and monitoring of handwashing. She also indicated the QAA committee is looking at staff turnover and ways to reduce the need to use a staffing agency nurses to staff the facility.</p> <p>The QAA committee consisted of the Executive Administrator, Director of Nursing, Assistant Director of Nursing, Director of Rehabilitation, Dietician and the Medical Director. The committee also included the Directors of Social Services, Human Resources, Activities, and Staff Development. The QAA Committee meets monthly and failed to implement adequate action plans to correct the identified concerns which included the following: not ensuring the dignity of residents during dining, not providing activities for cognitive impaired residents, not ensuring the safety of residents, not following</p>			

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	<p>Physician Orders, not keeping Foley catheter tubing off the floor, not providing clean kitchens and not protecting food from contaminations, not monitoring refrigerator and freezer temperatures and not storing foods in refrigerators with adequate labeling, not keeping the medication and treatment carts clean, not labeling over-the-counter medications adequately, not keeping medication carts/rooms free of expired treatment medication, and inadequate handwashing during meal services.</p> <p>On 11/21/14 at 4:39 p.m., the DON provided the Facility's current policy "Quality Assessment and Assurance Plan", with the approval date of April 2014, which indicated the following, "...This facility shall develop , implement and maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and to resolve identified problems....To provide a means whereby negative outcomes relative to resident care and safety can be identified and resolved....develop monitoring tools that provide an effective mechanism to assure that each resident receives the necessary care and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being....To develop plans of</p>			

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	correction and evaluate corrective actions taken to obtain the desired results...." 3.1-52(a)(2)				