STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155064		08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This was for the investigation of Complaints IN00206046 and IN00207175. Complaint IN00206046-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, F250, F309 and F312. Complaint IN00207175-Substantiated. Federal/State deficiency related to the allegations is cited at F371. Unrelated deficiencies are cited-F323. Survey dates: August 8, 9 and 10, 2016 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census bed type: SNF: 6 Residential: 66 Total: 72 Census payor type: Medicare: 3 Medicaid: 63 Other: 6 Total: 72	F 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on August 15, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member			

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	when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify a resident's Power of Attorney of changes of condition for 1 of 4 resident's reviewed for notification of change of condition (Resident B). Finding includes: Resident B's record was reviewed on 8/9/16 at 10:28 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and epilepsy without status epilepticus. The documentation indicated the following at these dates and times: A progress note dated 1/19/16 at 12:45 p.m., indicated "[Name of Resident] had a Grand Mal Seizure that lasted 4 minutes from beginning to end while in the dining room... VS [vital signs] were 170/80... MD [medical doctor] notified." A progress note dated 1/19/16 at 12:55 p.m., indicated "[Name of Resident]	F 0157	**F157** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B was assessed and the Power of Attorney of was notified and updated as well as the primary care physician. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected, however after review of current active residents no other	09/09/2016

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	started another grand mal seizure at this time that lasted 2 minutes... BP [blood pressure] 168/80... MD notified." A progress note dated 5/12/16 at 2:51 p.m., indicated "Res [resident] C/O [complained of] HA [headache] after seizure activity occurred for 45 seconds...." A progress note dated 5/13/16 at 3:40 p.m., indicated "Resident sitting on the toilet with CNA standing by and noted to have seizure activity lasting approx one and a half minutes... [Name of physician] notified, awaiting response." A progress note dated 7/25/16 at 12:20 a.m., indicated "Resident noted to be having seizure like activity. Shortness of breath noted lying flat and at rest. O2 sat 91% RA [room air]." A progress note dated 7/25/16 at 12:37 a.m., indicated "Resident sent to [Name of Hospital] via 911 per family's request... r/t [related to] unresolving seizure activity. POA, MD and DON aware." A progress note dated 7/25/16 at 1:43 a.m., indicated "Resident returned from [Name of Hospital] ER with no new orders. Was given Keppra 1000 mg		unreported change of condition was found. **3) Measures put into place/ System changes:** Nursing staff were re-educated on the component of F-tag 157 and the need of timely notification of a resident's Power of Attorney regarding changes of condition. Nursing staff will utilize the 24 hour Summary to identify residents that have experienced a change of condition. 24- Hour Summaries will be reviewed by the Director of Nursing/designee daily to identify those resident that may have had a change of condition. Any identified issues of concern will be immediately addressed **4) How the corrective actions will be monitored:** The responsible party for this plan of correction will be the Director of Nursing/designee, who will audit 2 resident records weekly to determine prompt notification of change is occurring Issues identified will be immediately addressed.. The results of these audits will be reviewed in Quality Assurance Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 9-9-2016	

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	[milligrams] IV...." A progress note dated 7/25/16 at 2:27 p.m., indicated "Writer called [Name of family member], resident's [family member] who was POA [Power of Attorney] back as requested. Resident's [POA family member] wanted to speak to writer about resident's [non-POA family member] and how many problems she is causing according to resident's [POA family member]. Writer informed her that the [non-POA family member] is in the facility at this time and asking many questions and gave her an example about the diabetic shoes. [POA Family member] thanked writer for answering the question but stated that she did not want any more information being given to the [Non-POA family member] that she needed to go through the family if she had concerns at this time. She also was concerned that her mother had a seizure yesterday evening and no one called to inform because the [non-POA family member] was physically in the facility at the time that it happened. [POA Family member] was concerned d/t [due to] being the POA that she was not called and informed that her mother had a seizure and was sent to the hospital...." A progress note dated 7/26/16 at 2:25 a.m., indicated "while in bed receiving			

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	pericare resident had a seizure with jerking/twitching of upper limbs and fluttering of eyelids. Activity lasted approx. 15 sec [seconds]. This was followed about 3-4 minutes later with some eyelid fluttering and hand tremors lasting a few seconds...Unable to contact POA but will attempt later." An Emergency Documentation form (Name of Hospital) dated 7/24/16 at 8:28 p.m., indicated the ER Physician indicated the resident had presented to the ER on this date with multiple seizures. The Physician indicated the (Family member, who was not the POA) and the resident was updated with the plan. The resident's record lacked documentation her POA (Family member) was notified of her seizure activity or she had a seizure and was sent to the hospital. During an interview on 8/10/16 at 3:59 p.m., the Director of Nursing indicated the resident's POA should be notified of changes in condition and transfers to the hospital. The Director of Nursing indicated the progress note dated 7/25/16 at 12:37 a.m., which indicated the POA was notified of the new order to send the resident to the hospital could have been			

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	the (Name of family member, who was not the POA) because that family member was with the resident when she was having the seizures. She indicated the (Name of family member) could have been notified since the (Name of family member, who was the POA) indicated she did not know about the seizures and the hospital transfer from the day before. A current policy titled "Change In Condition Physician Notification Overview Guidelines" dated 1/1/2014, provided by the Director of Nursing on 8/10/16 at 2:31 p.m., indicated "...Nursing Documentation... F. Responsible Party is to be notified of change in condition...." This Federal tag relates to Complaint IN00206046. 3.1-5(a)(2) 3.1-5(a)(4)			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure the Social	F 0250	**F250**	09/09/2016

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	Services Director (SSD) followed up on an Audiology appointment for a resident with impacted wax in her ears for 1 of 3 residents reviewed for hearing (Resident B). Finding Includes: Resident B's record was reviewed on 8/9/16 at 10:28 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and epilepsy without status epilepticus. An Audiology Exam Form dated 12/18/15, indicated the resident's hearing test could not be completed on that date due to wax in her ears. The PCP'S [Primary Care Physician's] choice for 3-5 days to soften wax, followed by irrigation AS (left ear) by facility. Retry next visit. Audiology Physician indicated the resident had "Deep impacted wax remains AS [left ear] post CR." "Rec [recommend] drops of PCP's [Primary Care] next visit." The recommendations was ear drops and irrigation. An "Audiology Visit Final List" dated 1/14/16, 1/19/16, 3/8/16, 3/17/16, and 5/5/16 did not have the resident's name on it for a follow-up visit. A "Grievance/Concern Form" dated		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B was seen by the audiologist. Recommendations were reviewed and Resident B was placed on the Audiologist list for follow up appointment. Her ears were cleaned.. **2) How the facility identified other residents:** A facility sweep was completed to identify any other resident that may have excessive ear wax. The audiologist was notified of any concerns noted and residents were place on the visit list.	

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	7/19/16 at 4:30 p.m., indicated Resident B's (Name of family member) arrived at the facility and observed the resident's ears to have ear wax present. A progress note dated 7/19/16 at 4:40 p.m., indicated the resident's POA was contacted to inform her the resident's (Name of family member) came to the facility today and found the resident's ear to be dirty. The POA was informed (Name of Company) Audiology was contacted to schedule an Audiologist to see Resident B to make sure her hearing was alright. During an interview on 8/9/16 at 12:30 p.m., (Name of Audiologist Physician) indicated Resident B was seen today. She indicated she removed an excessive amount of wax from both of Resident B's ears, but the left ear was worse than the right. She indicated she had seen the resident in December 2015, and had made a recommendation for ear drops to help with the wax due to impacted wax, so it could be removed at the next visit. She indicated she was expecting to see the resident at the next visit she did at the facility. She indicated she had recommended drops to be given prior to this visit, but she could not tell if they were given or not because ear drops were not always given for hard wax. She		**3) Measures put into place/ System changes:** Nursing staff were educated on timely follow up of audiology recommendations. Review of recommendations will be handled per Social Services who will initially review and submit to Nursing for follow up and completion. The Director of Nursing will review recommendations 2 times weekly to ensure timely follow through and initiation of recommendations Identified issues will be addressed timely **4) How the corrective actions will be monitored:** The responsible party for this plan of correction will be the Director of Nursing/Social Services Director/designee, who will monitor the audits conducted weekly on 2 residents to determine audiology recommendations have been implemented and care plans are reflective. Any identified issues will be immediately addressed. The results of these audits will be reviewed in Quality Assurance	

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	indicated the ear drop medication was also given to allow the impacted wax to move farther out of the ear canal to make it easier for the Audiologist to reach to remove it. During an interview on 8/10/16 at 3:44 p.m., the SSD indicated the Audiologist visited to the facility dependent on when she was around the area of the facility. She indicated she had to give the Audiologist's scheduler the list of resident's to be seen, then the scheduler would schedule her date to come to the facility. The SSD indicated residents could only have their hearing checked once a year, so that was probably the reason Resident B was not put on the list to be seen again. She indicated she did not know when she was seen on 12/18/15, there was recommendations for drops and she was to be seen on the next visit to get wax removed. The SSD indicated the Audiologist gave her the paperwork when she left the facility, then she gave the paperwork to the nurses. She indicated the nurses were responsible for ensuring the recommendations from the Audiologist list and her progress notes were followed through. The SSD indicated from now on, she would make sure the recommendations the Audiologist made were followed up on.		Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 9-9-2016	

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	This Federal tag relates to Complaint IN00206046. 3.1-34(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure recommendations made from an Audiologist Physician were followed for 1 of 3 residents being reviewed for hearing problems (Resident B). Finding includes: Resident B's record was reviewed on 8/9/16 at 10:28 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and epilepsy without status epilepticus. An "Audiology Visit Final List" dated 12/18/15, indicated Resident B was seen by the Audiologist on this date. Her prior ear exam was 10/3/14. The Audiologist	F 0282	**F282** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	09/09/2016

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	had documented "CR, [Cerumen removed] Drops" in the Schedule Notes area. An Audiology Exam Form dated 12/18/15, indicated the resident's hearing test could not be completed on that date due to wax in her ears. The PCP'S [Primary Care Physician's] choice for 3-5 days to soften wax, followed by irrigation AS (left ear) by facility. Retry next visit. Audiology Physician indicated the resident had "Deep impacted wax remains AS [left ear] post CR." "Rec [recommend] drops of PCP's [Primary Care next visit." The recommendations was ear drops and irrigation. There was no order or request sent to the PCP to order the ear drops and irrigation recommended by the audiologist in the resident's record. An "Audiology Visit Final List" dated 1/14/16, 1/19/16, 3/8/16, 3/17/16, and 5/5/16 did not have the resident's name on it for a follow-up visit. A "Grievance/Concern Form" dated 7/19/16 at 4:30 p.m., indicated Resident B's (Name of family member) arrived at the facility and observed the resident's ears to have ear wax present.		Resident B's care plan was reviewed/ revised to reflect audiological interventions were in place. **2) How the facility identified other residents:** A facility sweep was completed to identify any other resident that may have excessive ear wax. Care plans were revised as appropriate. The audiologist was notified of any concerns noted. **3) Measures put into place/ System changes:** Nursing staff were educated on timely follow up of audiology recommendations as well as care plan revisions. The Director of Nursing will review audiological recommendations 2 times weekly to ensure timely follow through, initiation of recommendations, and care plan completion Identified issues will be addressed timely **4) How the corrective actions will be monitored:** The responsible party for this plan of	

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	A progress note dated 7/19/16 at 4:40 p.m., indicated the resident's POA was contacted to inform her the resident's (Name of family member) came to the facility this date and found the resident's ear to be dirty. The POA was informed (Name of Company) Audiology was contacted to schedule an Audiologist to see Resident B to make sure her hearing was alright. A document titled "Urgent Notice!" with a fax date 7/20/16, indicated "[Name of Resident] is scheduled for a hearing evaluation with [Name of Audiologist] on 8/9/16. During the last exam the audiologist recommended an order from the primary care physician for ear drops to soften the impacted wax in the patient's ear(s). Please contact the PCP for [Name of resident] and advise him the audiologist is requesting a physician order for drops to assist in cerumen removal. Often a primary care physician seeks guidance regarding the order. A common regimen is listed below. If you have questions or are unable to obtain the order please contact [Name of staff member at company] at [phone number]... Common regimen Medication: Carbamide Peroxide-Otic Indication: Impacted Cerumen Route: AU [both ears] Dosage: 5 gtts [drops] BID [twice daily] for 4 days Start date: 8/5/16 a.m.		correction will be the Director of Nursing/designee, who will monitor the audits conducted weekly on 2 residents to determine audiology recommendations have been implemented and care plans are reflective. Any identified issues will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 9-9-2016	

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	End date: 8/8/16 p.m." There was no order or request sent to the PCP to order the ear drops recommended by the Audiologist for the visit on 8/9/16 in the resident's record. During an interview on 8/9/16 at 12:30 p.m., (Name of Audiologist Physician) indicated Resident B was seen today. She indicated she removed an excessive amount of wax from both of Resident B's ears, but the left ear was worse than the right. She indicated she had seen the resident in December 2015, and had made a recommendation for ear drops to help with the wax due to impacted wax, so it could be removed at the next visit, but she did not see her until this visit. She indicated she was expecting to see the resident at the next visit she did at the facility. She indicated the drops ordered were for this visit, but she could not tell if they were given or not because ear drops were not always given for hard wax. She indicated the ear drop medication was also given to allow the impacted wax to move farther out of the ear canal to make it easier for the Audiologist to reach to remove it. On 8/9/16 at 4:40 p.m., the Medical Record staff member provided a copy of the "Urgent Notice!" with "faxed 7/20/16,			

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	and a signature written at the bottom of the recommendation. She indicated at that time, she did not find any orders or documentation to indicate the 12/18/15 recommendation from the Audiologist had been addressed. She indicated it was a recommendation, not an order. She indicated she did not know the Audiologist progress notes indicated the resident had deep impacted wax and the medication was recommended to try to remove the wax at the next visit. She indicated the recommendation sent from the Audiologist on 7/20/16, for the ear drops was faxed to the PCP on 7/20/16. She indicated she found a copy of the faxed copy at the nurses station. She indicated she did not know why the PCP had not been contacted again since 7/20/16, to get the order for the medication for the Audiologist appointment today, but it was refaxed today. She did not know the Audiologist had cleaned the resident's ears prior to the PCP being refaxed for the medication. During an interview on 8/10/16 at 3:59 p.m., the Director of Nursing indicated recommendations from the Pharmacy were faxed to the Physicians. She or the Assistant Director of Nursing (ADON) gave the recommendations to the nurses to fax. She indicated the Social Service Director took the recommendations from			

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	(Name of Company) for the Podiatrist, Audiologist, Dentist and Optometrist and she would give those to the nurses, DON or ADON to follow up on. She indicated those recommendations were given to the Physicians when they were at the facility or faxed to them. She indicated she expected the follow-up time for recommendations to be 3-4 days, then the nurses should notify the resident's Physician regarding the recommendation. She indicated the 12/18/15, recommendation from the Audiologist, she had only been here a few weeks, so she was not aware of that recommendation. She indicated the Medical Records staff member could not find an order for that recommendation. She indicated the recommendation from 7/20/16, which was faxed to her physician was not followed up on. This Federal tag relates to Complaint IN00206046. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest			

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	practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to monitor Levetiracetam levels (blood tests to check the amount of this drug in the blood for a therapeutic dose) on a resident who had a diagnosis of seizures for 1 of 6 residents reviewed for laboratory result monitoring (Resident B) and a lack of assessments for a change in condition for 1 of 4 residents reviewed for change of conditions (Resident D). Finding includes: Resident B's record was reviewed on 8/9/16 at 10:28 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and epilepsy without status epilepticus. The documentation indicated the following at these dates and times: A progress notes dated 12/14/15 at 7:00 p.m.--"at 6:05 p.m. res had grand mal seizure lasting approx. [approximately] 2 min [minutes], able to respond, but had another seizure lasting 1 min. Dr. [doctor] notified and order given to send to ER [Emergency room]... BP [blood pressure] 170/94...."	F 0309	**F309** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents # B and# D were assessed, orders reviewed, care plans revised. **2) How the facility identified other residents:**	09/09/2016

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	A progress notes dated 1/18/16 at 6:41 p.m.--"at 545 [5:45 a.m.] patient noted having multiple mild seizures noted lasting 20-30 seconds... Notified POA [Power of Attorney]. Notified MD. [Name of Neurologist] scheduled to visit patient in house for seizures . Keppra [a seizure medication] [same as Levetiracetam] and Dilantin [a seizure medication] labs ordered in AM [morning]." Neurologist Progress note dated 1/18/16, indicated "...Visit type:New patient evaluation... Chief Complaint: Possible seizures. History of Present Illness: Seizures started many years ago. History is fairly sparse, patient states she has had seizures may years and does not recall any triggering event. Current seizure frequency is 2-3 per week reportedly... Medications:..levetiracetam [medication to treat seizures] 500 mg [milligrams] oral tablet 1 tab (s) (500 mg) po [by mouth] bid [twice daily]...." A laboratory result dated 1/19/16 at 8:28 a.m., with a last reprint date 8/10/16 at 1:30 p.m., indicated "Refusal (First attempt) Resident has refused lab work for today. We will try to obtain specimens two more times and then order will be discontinued due to residents		A facility audit was conducted to identify those residents receiving Levetiracetam to determine current lab monitoring was available, as well as those residents that currently have a diagnosis of Congestive Heart Failure to determine appropriate interventions are in place for assessments. **3) Measures put into place/ System changes:** The licensed nursing staff were in serviced on Lab Monitoring, Care Plans and documentation of assessments for those individuals exhibiting a change in condition. Lab monitoring calendars were placed at each nursing unit. Order listing reports will be reviewed daily by the Director of Nursing/designee to determine timely completion and review of lab results with appropriate physician notification. Nursing staff will utilize the 24 hour Summary to identify residents that have experienced a change of condition. 24- Hour Summaries will be reviewed by the Director of Nursing/designee daily to identify those resident that may have had a change of condition.	

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	wishes. Please inform Physician of patient's refusal for lab work. Notified Nurse: [Name of nurse] Lab will redraw (date) 1/21/16. Tests ordered: Dilantin, Levetiracetam." A laboratory result dated 1/20/16 at 4:40 p.m., with a last reprint date 8/10/16 at 1:30 p.m., indicated "Dilantin (Phenytonin) 7.7 (L) [low] 10-20 ug [micrograms]/ml [milliliter] UTO [unable to obtain]-Specimen not collected. Notified Nurse: [Name of Nurse] Lab will redraw: 1/21/16. Tests Ordered: UA [urinalysis] W [with] CLT [culture]." A progress note dated 1/19/16 at 12:45 p.m., indicated "[Name of Resident] had a Grand Mal Seizure that lasted 4 minutes from beginning to end while in the dining room... VS were 170/80... MD was notified." A progress note dated 1/19/16 at 12:55 p.m., indicated "[Name of Resident] started another grand mal seizure at this time that lasted 2 minutes... BP 168/80... MD notified." A Neurologist progress note dated 4/7/16, indicated "...Chief Complaint possible seizures. History of Present Illness: Patient has minor seizures a few times		Any identified issues of concern will be immediately addressed **4) How the corrective actions will be monitored:** The responsible party for this plan of correction will be the Director of Nursing/designee, who will audit 2 resident records weekly to determine timely Lab monitoring and assessments are reflective of change in conditions. Issues identified will be immediately addressed.. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 9-9-2016	

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	per week...Medications:..Levetiracetam 500 mg oral tablet 1 tab (s) (500 mg) po bid... Impression and Plan:.. Plan: 1. Increase Keppra [same as Levetiracetam] 750 mg BID [twice daily]. 2. Keppra level in one week. 3. Stop tramadol as can lower the seizure threshold." A laboratory result dated 4/14/16 at 8:22 a.m., with a last reprint date 8/9/16 at 3:58 p.m., indicated "Refusal (First Attempt) Resident has refused lab work for today. We will try to obtain specimens two more times and then order will be discontinued due to residents wishes. Please inform Physician of patient's refusal for lab work. Notified Nurse: NA. Lab will redraw: NA Tests ordered: Levetiracetam." A Neurologist progress note dated 5/6/16, indicated "...Chief Complaint: seizures. History of Present Illness: Reportedly last seizure 4/23/16. Dilantin dose increase at that time. Staff laso [sic] requests alternative to Dilantin extended tabs because they have to crush her medication now. Patient remains on Keppra that was increased early in April, but do not find Keppra level ordered for 2 weeks later...Plan: 1. Increase Keppra 1000 mg BID. 2. Keppra level in one week...."			

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	A progress note dated 5/12/16 at 2:51 p.m., indicated "Res [resident] C/O [complained of] HA [headache] after seizure activity occurred for 45 seconds...." A laboratory result dated 5/13/16 at 3:48 p.m., with a last reprint date 8/9/16 at 5:31 p.m., indicated Levetiracetam (Keppra) 3 (low) Normal 6-46 ug/ml. A progress note dated 5/13/16 at 3:40 p.m., indicated "Resident sitting on the toilet with CNA standing by and noted to have seizure activity lasting approx one and a half minutes... [Name of physician] notified, awaiting response." A Neurologist progress note dated 7/14/16, indicated "...Chief Complaint: seizures. History of Present Illness: seizure on week ago, usually once every few months... Visit 5/6/16: Reportedly last seizure 4/23/16... Patient remains on Keppra that was increased early in April, but do not find Keppra level ordered for 2 weeks later... Medications:.. Keppra 1000 mg oral tablet 1 tab (s) (1,000 mg) po bid... Results review: Lab results: 5/13/16 10:18 AM Levetiracetam Level... 3 mcg [micrograms]/mL... Plan: 1. Increase Keppra 1500 mg BID. 2. Keppra level in a few weeks...."			

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	A progress note dated 7/25/16 at 12:20 a.m., indicated "Resident noted to be having seizure like activity. Shortness of breath noted lying flat and at rest. O2 sat 91% RA [room air]." A progress note dated 7/25/16 at 12:37 a.m., indicated "Resident sent to [Name of Hospital] via 911 per family's request... r/t [related to] unresolving seizure activity. POA, MD and DON aware." A progress note dated 7/26/16 at 2:25 a.m., indicated "while in bed receiving pericare resident had a seizure with jerking/twitching of upper limbs and fluttering of eyelids. Activity lasted approx. 15 sec [seconds]. This was followed about 3-4 minutes later with some eyelid fluttering and hand tremors lasting a few seconds...Unable to contact POA but will attempt later." Resident B's record lacked a laboratory result for 1/19/16, 4/14/16 and approximately 5/27/16 Keppra level. During an interview on 8/10/16 at 3:59 p.m., the Director of Nursing (DON) indicated she thought the resident had refused some labs. She indicated she was told Resident B refused a Keppra level, then she was off. The DON indicated she			

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	did not know anything about the missing laboratory results. She indicated if the Medical Record staff member did not provide the missing laboratory results, then she was unable to locate them. 2. Resident D's record was reviewed on 8/9/16 at 3:30 p.m. Diagnose included, but were not limited to, generalized edema, hypertension, combined systolic and diastolic heart failure, pacemaker, acquired absence of right and left below knees and difficulty in walking. The resident had a Care Plan dated 10/25/15, which addressed the problem he had Congestive Heart Failure. Interventions included, but were not limited to, "10/25/15--Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing...10/25/15- -Monitor/document/report PRN [as needed] any s/sx [sign/symptom] of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB [shortness of breath] upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain, unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (Tachycardia), lethargy and			

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	disorientation." The documentation indicated the following at these dates and times: A progress note dated 8/1/16 at 2:57 a.m., indicated the Physician was notified of the increased swelling to the resident's left arm with pitting edema. His forearm was cool to the touch and his bilateral lower extremities and trunk pitting edema and he had an occasional dry cough. His lung sounds were diminished bilaterally. He complained to the evening shift nurse he had shortness of breath, which was resolved with an as needed Nebulizer treatment. A progress note dated 8/1/16 at 1:58 p.m., indicated the resident had 2+ pitting edema to his left arm and it was cool to touch. He had shortness of breath with exertion. Physician to assess resident today. A progress note dated 8/2/16 at 1:16 p.m., indicated the resident had 2+ pitting edema to his left arm and thighs. He was short of breath with exertion. No cough or pain. A progress note dated 8/2/16 at 6:59 p.m., indicated the resident had 2+ edema to his left arm and both legs. He had shortness of breath if lying flat or with			

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	exertion of propelling self in his wheelchair. A progress note dated 8/4/16 at 3:59 p.m., indicated (Name of Physician) called and notified of the resident's edema in his trunk, arms and bilateral above the knee thighs. He had a followup appointment with this physician on 8/12/16, and has been placed on the cancellation list. A progress note dated 8/6/16 at 1:38 p.m., indicated swelling continued to the left arm. 2+ edema to his thighs and trunk. He was short of breath while laying flat and with exertion. He had a dry cough at times. A progress note dated 8/9/16 at 4:33 p.m., indicated the Physician was notified of the increased edema of the left arm, the left arm being cool to the touch, edema of the thighs and trunk, breath sounds coarse bilaterally. His respirations were 22. The Physician gave an order to admit the resident to (Name of Hospital). There was a lack of assessments of the resident's lung sounds, amount of edema to extremities or trunk, temperature of skin, color of skin, mental status, and whether the resident was short of breath			

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	from 8/1/16 to 8/9/16 prior to the resident being admitted to the hospital. During an interview on 8/10/16 at 4:30 p.m., the Director of Nursing indicated Resident D was admitted to the hospital for Systolic Congestive Heart Failure. She indicated the resident was assessed for a change of condition from 8/1/16 to 8/9/16. She indicated he had his vital signs checked, he was weighed daily, a NAR (Nutrition at Risk) note was documented on 8/4/16, pain assessments were completed and he was assessed for interactions for all his medications. She indicated his Physician seen him two to three times a week and wrote progress notes. She checked the Physician progress notes at that time and indicated the last progress note was dated 7/2/16. She indicated the resident had been treated at the facility with IM (Intramuscular) Lasix (a medication used to remove extra water from the body). She indicated she had no further assessments to provide documenting the residents lung sounds, amount of his edema to his extremities and trunk, temperature of his skin, color of his skin, his mental status, and whether he was short of breath or had a cough. The Director of Nursing indicated the resident was assessed on 8/9/16, then she notified his Physician and told him she thought			

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	giving the resident anymore Lasix IM was not going to help him and she thought he needed to go to the hospital. A current policy titled "Laboratory-Test Processing and Reporting" undated, provided by the Director of Nursing on 8/10/16 at 2:31 p.m., indicated "Purpose: To assure physician-ordered diagnostic tests are performed, and to assure that test results are promptly reported to the physician. Responsibility: Licensed Nursing and Director of Nursing. Standards: 1. A licensed nurse is responsible for assuring the laboratory is notified of physician's orders for testing...4. A nurse is responsible for monitoring all test results received. 5. Test results are promptly reported to the physician or other practitioner who ordered them, and their response documented in the medical record... 7. The licensed nurse is responsible for documenting physician notification in the resident's medical record." This Federal tag relates to Complaint IN00206046. 3.1-37(a)			
F 0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT			

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Bldg. 00	RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to provide ear care as part of a resident's personal hygiene for 1 of 6 residents reviewed for ADL's (Activities of Daily Living) (Resident B). Finding includes: Resident B's record was reviewed on 8/9/16 at 10:28 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and epilepsy without status epilepticus. A "Grievance/Concern Form" dated 7/19/16 at 4:30 p.m., indicated Resident B's (Name of family member) arrived at the facility and observed the resident's ears to have ear wax present. A progress note dated 7/19/16 at 4:40 p.m., indicated the resident's POA was contacted to inform her the resident's (Name of family member) came to the facility today and found the resident's ear to be dirty. The POA was informed (Name of Company) Audiology was contacted to schedule an Audiologist to see Resident B to make sure her hearing	F 0312	**F312** **1.) What corrective actions will be accomplished for those residents found to be affected?** Resident #B was provided ear care. Licensed nursing staff and C.N.A's were re-educated on provision of ADL care. **2.) How will the facility identify other residents?** A facility sweep was completed to identify any other resident that may have excessive ear wax. The audiologist was notified of any concerns noted and residents were place on the visit list. Those residents identified were assessed and ADL care plan revisions were completed. **3.) What measures will be put into place to ensure the practice does not recur?**	09/09/2016

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	was alright. During an interview on 8/9/16 at 11:50 a.m., the Social Services Director indicated Resident B's ears were "dirty" on 7/19/16 when her (Name of Family Member) came to visit and a grievance was filed. She indicated the (Name of family member) had used cotton swabs to clean her ears, then talked with the Director of Nursing about the resident's ears. The Director of Nursing indicated she was going to do an ear cleaning sweep of the whole facility. The Social Service Director indicated she called and scheduled the Audiologist to come and see Resident B and other residents who had "dirty" ears to check their hearing. During an interview on 8/10/16 at 3:59 p.m., the Director of Nursing indicated Resident B's (Name of family member) was at the facility on 7/19/16, and she complained the resident had wax on her outer ears. The Director of Nursing indicated Resident B did have wax on her outer ears. She indicated the wax washed off her ears easily with a wash cloth and she apologized to the (name of family member). This Federal tag relates to Complaint IN00206046.		Nursing staff was re-educated on the provision of ADL care, i.e. personal hygiene/ear care. Director of Nursing/ designee will randomly interview 2 residents weekly that require assistance with ADL care to include the provision of ear hygiene. Any issue identified will be immediately addressed. **4.) How will the corrective actions be monitored?** The responsible party for this plan of correction is the Director of Nursing/designee. Audits will be conducted by the Director of Nursing/designee on 2 residents weekly to determine appropriate ear care has been provided. Identified concerns will be addressed timely. The results of these audits will be reviewed in Quality Assurance Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5.) Date of Correction**	

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	3.1-38(a)(3)(A)		9-9-2016	
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure potentially hazardous chemicals were secured for 2 of 4 storage rooms, 1 of 4 linen closets and failed to lock 1 of 3 treatment carts. These deficient practices had the potential to affect 32 of 46 residents who were capable of independently moving through the facility and failed to ensure secured and locked exit doors maintained a functional key pad to allow exit for 1 of 2 secured exits. Findings include: 1. On 08/08/2016 at 10:50 a.m., the following observations were made: a. A storage room located on Redbud unit was unlocked and the door was ajar. The contents of the storage room were as	F 0323	**F323** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.) Immediate actions taken for those residents identified** No resident was affected. Issue 1a) the door to the storage	09/09/2016

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	follows: One bottle of Murphy Oil soap. One can of Mastic remover (for removing adhesives). One gallon container of cleaning soap, 1/3 full and lacked a lid. Two cans of carpet stain remover. Two boxes containing 12 cans each of baseboard and wax build up stripper. One bottle of hospital germicide disinfectant spray. Two bottles of carpet shampoo. A 12 volt battery charger was plugged into the wall and attached to the large floor cleaner battery sitting on the floor. At that time, the Housekeeping/Laundry Supervisor indicated the door was always very hard to close. She indicated, "it takes a man" to close the door and it had not closed correctly for some time. During an interview, on 08/08/2016 at 10:55 a.m., the Administrator (ADM) indicated the battery charger was insulated and caused no potential threat to the residents. He indicated he was unaware the door to the storage room was difficult to close. b. At 11:20 a.m., on the Walnut unit, a door labeled "Janitor's closet" was observed open. The closet contained two cans of floor stripper. At that time, the		room on the Redbud unit repaired and locked. Issue 1b).the janitor's door was closed and locked on the Walnut Unit. Housekeeping staff were educated on locking chemicals. Issue 1c.) the linen closet on the Walnut unit was cleared on all non-linen products, repaired closed and locked. Facility wide linen and janitor closets were checked for correct locking and operation. Issue 1d.) Treatment cart was immediately locked and LPN #1 was in-serviced 8-9-2016 on locking treatment carts/medications carts. Safe Care technician replaced the key pad to locked unit. Nursing, Ancillary, and Maintenance staff educated on green emergency buttons and immediate notification of appropriate management for any malfunctioning of the key pad. **2) How the facility identified other residents:** Any resident that is currently living in the facility and independently mobile had the potential to be	

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	Maintenance Director indicated the fire inspection person was in the building and had left the door unlocked. c. At 11:25 a.m., on the Walnut unit, a linen closet with a key pad was observed to be unlocked. The contents of the linen closet included: Miscellaneous linens were stored on shelves. Contained in a box of linen sitting on the floor were Hoyer lift slings, one can of shaving cream, one box of denture tablets, one can of deodorizer spray, several tooth brushes, tissues and two bottles of hair/body wash. At that time, the Medical Records staff member indicated the linen door should be locked. She indicated they kept additional personal items in the linen room to help the staff from running to the other side of the building to retrieve supplies. The ADM indicated at that time, the door should be locked. He attempted to open the closed door and it freely opened. He examined the door at that time and indicated the door had a screw missing. d. On 08/09/2016 at 3:52 p.m., a resident treatment cart was observed to be unlocked, unattended and sitting in the hallway outside room 108.		affected, however none were identified Medication/treatment carts will remain locked if not attended. A facility wide review was completed on facility key pad entry locks to determine correct functioning, which includes all janitors and linen closets. **3) Measures put into place/ System changes:** Facility staff educated on the components of F323 and maintaining a safe, hazard free environment, Emergency door release buttons, and immediate notification of Administrator/DNS/ and Maintenance Director should the keyless entry pads malfunction. The Maintenance Director will record/ log when repairs are completed. **4) How the corrective actions will be monitored:** Medication/Treatment Carts will be randomly audited 2 times weekly by the Director of Nursing or the Assistant Director of Nursing for	

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	On 08/09/2016 at 3:58 p.m., LPN #1 walked out of room #110 and locked the treatment cart. At that time, LPN #1 indicated the treatment cart should always be locked. On 08/09/2016 at 4:25 p.m., the following was observed to be in the treatment cart: A&D ointment (a skin protectant) -one tube Dermacol (collagen) dressings -three dressings Ketoconazole 2% (antifungal) shampoo -one bottle Ketoconazole 2% (antifungal) cream -one tube Tucks Medicated Pads (hemorrhoidal treatment) -one container Hydrogel (wound care treatment) -one tube Eucerin body wash -one bottle Cerave Hydrating cleanser (medicated face wash) -one container Aveeno cream (moisturizer) -one bottle Nystatin 100,000 units powder (antifungal) -one bottle Nystatin 100,000 units cream (antfungal) -one tube Santyl gel (wound care treatment) -one tube Theragesic cream (pain relief cream) -one tube		correct security. Maintenance Director will audit 2 times weekly and through daily routine facility rounds accurate locking of all keyless entry pads as well as appropriately locked closets and storage areas. Housekeeping Director will audit 2 times weekly through facility rounding all chemicals are stored correctly and kept behind locked doors. The results of these audits will be reviewed in Quality Assurance/Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. . **5) Date of compliance**: 9-9-2016	

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	Triamocolone 0.1% cream (antifungal) -three tubes Lac Hydrin 12% lotion (medicated skin lotion) -one bottle Ammonium Lactate 12% cream (medicated cream for skin) -one tube Hand Sanitizing gel (65% alcohol) -one bottle Sodium sulfacetamide 10% (medicated skin wash) -one bottle Lubricating deodorant -one bottle Calmoseptine (skin protectant) cream -one tube Eucerin cream -one tub Normal saline bullets -ten bullets Vani Cream (medicated skin cream) -one tube Xero derm gauze -two sheets (wound dressing) 3. On 8/8/16 at 11:40 a.m., attempted to exit the Harmony unit exit doors into the Walnut Unit and the exit doors would not unlock when the door code was put into the key pad. The code was put into the key pad three times. The code was clarified with CNA #4, which was the correct code. Attempted to unlock the doors again by putting the code in the keypad two more times without success. CNA #4 put the code into the keypad two times and the exit doors would not unlock. CNA #5 attempted to unlock the doors by putting the code into the key pad			

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	three times and on the third time, the exit doors unlocked. CNA #5 indicated at that time, "the doors have a mind of their own and they have been doing this for awhile." She indicated sometimes the exit doors unlocked on the first try and sometimes it took three tries. On 8/8/16 at 11:50 a.m., the Maintenance Director and the Administrator came to the Harmony Unit and the Maintenance Director put the code into the key pad and the exit doors unlocked on the first attempt. The Maintenance Director indicated if the code is entered to fast it messed the code box up and the box would have to have time to reset. The Administrator indicated in an emergency the exit doors automatically unlocked. He indicated if these exit doors did not unlock, the staff could take the residents out the other set of exit doors or they could take them out the exit door into the courtyard. The Administrator indicated he would have (Name of the Company) come out and check the code box to be safe. During an interview on 8/8/16 at 12:30 p.m., CNA #5 indicated the key pad box acted up occasionally, but not as bad as it had today. She indicated she had forgotten there was a push button to open each exit door in an emergency if they			

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	would not unlock. During an interview on 8/8/16 at 12:40 p.m., CNA #4 indicated the last fire alarm, which went off, the exit doors locked and would not open. She indicated she pushed the green button "Push to Exit" at the nurses station and another staff member opened the exit door going onto the Walnut unit and that was how the staff get the exit doors open. She indicated she did not know what the green buttons were for, she tried the buttons to see what they did. She indicated not all the staff knew what the green buttons were used for. QMA #6 indicated at that time, she did not know about the green buttons opening the exit doors if they were locked and would not open. On 8/8/16 at 2:35 p.m., Technician #7 from (name of company) came to the facility to check the key pad and box for the exit doors on the Harmony unit. He indicated at that time, there was pressure from the key pad box on the LED lights, which he thought was causing the key pad from connecting every time the code was entered. He replaced the key pad and fixed the box, so there was no pressure on the box. the Maintenance Director indicated at that time, he had not received a work order for the key pad			

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	malfunctioning. The Harmony unit staff (CNA's) indicated earlier they had not notified the Maintenance Director the key pad was not functioning correctly. During an interview on 8/8/16 at 2:45 p.m., Floor Tech #8 indicated an alarm was pulled by a female resident on the Harmony unit on night shift and he came in. He indicated he was not aware the doors did not unlock that night when he came in to silence the alarm. He indicated he knew about the green buttons were to open the Harmony unit exit doors in an emergency, but he had forgot about them. The Maintenance Director indicated at that time, he did not know about the green buttons and the Administrator did not indicate whether he knew about the buttons or not. A current policy titled, "STANDARDS & GUIDELINES: STORAGE OF CHEMICALS" dated 05-01-2015, provided by the Director of Nursing on 08/10/2016 at 11:14 a.m., indicated "...STANDARD: All Housekeeping and Laundry chemicals shall be stored in an area designated as a Janitorial Closet and it will be kept locked at all times...." 3.1-45(a)(1) 3.1-45(a)(2)			

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F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to maintain a clean and sanitary kitchen and kitchen practices and failed to maintain clean and sanitary nutrition pantries for 3 of 4 resident pantries. This deficient practice had the potential to affect 72 of 72 residents receiving food from the kitchen or nutrition pantries. Findings include: On 08/09/2016 at 3:20 p.m., the kitchen and nutrition pantry tour began with the Dietary Manager (DM) in attendance. The following observations were made in the kitchen: a. Dietary aide #2 was not wearing a hair net. b. Black colored and food debris were on the floor, baseboards and around the	F 0371	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F371 Kitchen Sanitation **(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:**	09/09/2016

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	perimeter of the dishwashing room. c. A soiled, gray dish towel was lying on the floor by the three compartment sink. At that time, the DM indicated the towel should have been placed in the soiled laundry. d. Food debris was on the floor behind the ice machine. e. The ice machine's inner lid and base had dry, flaky beige debris noted. f. The ice cream freezer had brown, pink and black debris on the rubber gasket and base. At that time, the DM indicated the black substance was mold. g. Three metal drawers beneath the coffee maker were observed to have: The first drawer contained bagged teas and had scattered food debris. The second drawer contained cloth aprons and had a brown and black colored substance adhered to the right rear of the drawer. The third drawer had several rusted areas and contained cloth aprons and scattered, dry food particles. The walk in cooler contained: h. Seven bags of undated, unlabeled yellow liquid. The DM indicated the yellow substance was liquid eggs. One		#1-Dietary Aide #1 was educated on wearing hair net. Hair net was donned. #2 Black colored and food debris was cleaned from the perimeter, baseboards of dishwashing room floor. #3 The soiled gray dish towel was placed in soiled laundry. #4 The floor behind the ice machine was cleaned. #5The ice machine’s inner lid and base was cleaned. #6 The dietary manager and kitchen staff were immediately educated on ensuring the blender container and blades were dry before utilizing to puree food. #7 Ice Cream freezer was cleaned #8 The three metal drawers beneath the coffee maker were cleaned #9 The walk in cooler was cleaned, and food was labeled and dated.	

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	gallon pitcher of orange colored fluid without a label or date. The DM indicated the orange colored fluid was thickened orange juice. i. A moderate amount of dried cereal was found on a rack beneath the cereal bags. The walk in freezer was observed to have a temperature of -15 F. (Fahrenheit) j. The walls, ceilings, floors, racks and all food items were covered with ice crystals and frost. The DM indicated at that time, the freezer door had a faulty rubber gasket and a faulty heating element and had been evaluated by a service company one week ago. She indicated the company had ordered replacement parts that should be in this week. 1. The resident refrigerator on the Red bud nutrition pantry contained: Large amounts of ice crystal build-up were observed to the upper portion of the unit. a. One gallon pitcher, half full of a orange liquid was without date or label. b. One gallon pitcher, half full of a yellow liquid without date or label. c. One 32 ounce Styrofoam cup with brown fluid without label or date. d. One 16 ounce water bottle with bright		#10 Dried cereal was cleaned from beneath the cereal bags #11 the walk in freezer faulty rubber gasket and heating element that was ordered prior to survey arrived and was replaced. The refrigerator on Redbud pantry was defrosted, and all unlabeled products were discarded. Refrigerator was cleaned The refrigerator on Walnut unit was cleaned and defrosted. All unlabeled and dated products were destroyed. The refrigerator was cleaned. The refrigerator on the Harmony Unit. Was cleaned. Any product that was not dated and labeled was destroyed. Dietary Aide #3 was in serviced on hand hygiene, food temperatures and sanitation of temperature probe. Dietary Consultant was provided education on appropriate hand hygiene and	

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	pink fluid without label or date. e. Two frozen dinners without label or date. At that time, the DM could not indicate whose or what liquids were in this refrigerator, or who the frozen dinners belonged to. 2. The resident refrigerator on the Walnut nutrition pantry contained: a. Large amounts of ice crystal build-up was observed to upper portion of the unit. b. One bottle of Underberg herbal supplement with soiled label identifying the substance, but no label identifying the owner or date. c. One, large clear plastic container with green lid was sitting on its side in the unit door. The container was leaking a foul smelling orange fluid and when opened by the DM, it contained a foul smelling, greenish colored cantaloupe. The container lacked a label or a date. d. One carton of Resource 2.0 resting on its side and had leaked onto the refrigerator base lacked an open date and a label. e. One quarter of a bag of shredded		**(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Any resident who receives food from the kitchen has the potential to be affected; however, none was found to be affected. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** The Dietary Manager and food service staff were educated by the Executive Director on the federal requirement of F371 and the importance of keeping all foods covered, labeled and dated correctly, wearing appropriate hair coverings; and keeping the dietary/kitchen department in a clean and sanitary condition. Additional education was provided for hand hygiene, sanitation and use of temperature probe. Executive Director/designee will check for optimum sanitation, correct storage of the dry storage area, freezer storage, and walk-in storage areas two times weekly, as well as accurate food temps with proper handling and sanitation.	

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	cheese was opened, uncontained and lacked a label or a date. f. One 16 ounce container labeled "sour cream", contained left over orange and brown colored food. The container lacked a label or a date. At 4:07 p.m., the DON indicated employees were not to store personal foods or fluids in the nutrition pantries on the units. She also indicated she was unsure of who was responsible to clean the pantry refrigerators. She indicated she would need to check to be sure. 3. Harmony Unit nutrition pantry contained the following: a. The top of the refrigerator was covered in dust and scattered trash and dry food items. b. One bag labeled "Rice Crispies" had a plastic cup resting in the zip-locked, sealed bag with the cereal. c. One half eaten, open snickers candy bar was sitting in the freezer and lacked a label or a date. d. One beef and cheddar wrap was sitting in the freezer with expiration date of 05/17/16.		**(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The Dietary Manager will perform an audit 5x weekly of all food storage areas to determine accurate dating and labeling of all food products, sanitation, hand hygiene and correct use of temperature probes. Executive Director/designee will check audits of Dietary manager 2 x weekly for accuracy. The RD will check the Kitchen Sanitation and Storage procedures during her facility visits. Any sanitation issues will be brought to the attention of the Dietary Manager, Executive Director, and any other applicable staff. The results of these audits will be reviewed in Quality Assurance Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **Date of compliance** **9-9-2016**	

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	e. One quarter full bottle of blue Gatorade was in the freezer without an open date or a label. f. One half full frozen milkshake from McDonalds was in the freezer without a date or a label. g. One half full bottle of Powerade was in the freezer without label or a date. h. One half full pint of butter pecan ice cream was without label or a date. i. One half full gallon pitcher with orange liquid had no label or a date. j. One half full gallon pitcher with yellow liquid had no label or a date. k. One, square plastic container without a lid was half full of coffee with a small plastic cup resting on the coffee. The container lacked a label or a date. l. One bottle of half full soy sauce contained no open date. m. One bottle of quarter full bacon bits contained no open date. On 08/09/2016 at 4:20 p.m., the DON indicated it was the responsibility of			

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	housekeeping to clean and maintain the nutrition pantry refrigerators. 4. On 08/10/2016 at 11:27 a.m., Dietary aide #3 was observed to perform food temperatures before the lunch service. She was not observed to perform hand hygiene prior to obtaining the temperature probe. She began by inserting the probe into the fried chicken and obtained a temperature of 190.4 F followed by inserting the probe into the macaroni and cheese to obtain a temperature of 93.1 F. When asked what the temperature should be for meal service, she indicated the temperature the foods were to be served at were located in the blue dietary book. She indicated she did not know what the temperature should be. She followed by inserting the temperature probe into the ground beef and obtained a temperature of 166.0 F. When asked about the use of a temperature probe wipe, she indicated she had never used them and did not know where they were. At that time, the DM indicated a temperature probe wipe was to be used after checking the temperature of each food item and the macaroni and cheese should be kept at 165 degrees. At 11:43 a.m., the Dietary Services Consultant removed the temperature			

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	probe from the hands of Dietary Aide #3 as he stood in the food service area outside of the kitchen and reached through the service window. Without performing hand hygiene, he obtained a temperature for the pork tortilla rolls at 103.3 F. Dietary Aide #3 continued to stand at the serving line after the pork rolls were temped at 103.3 F. The Dietary Consultant instructed Dietary Aide #3 two times to place the rolls back into the oven to warm them to proper serving temperature. At that time, Dietary Aide #3 gathered trash from the counter, lift the lid of the trash can with her right hand and proceed to put on an oven mitt to place the pork tortillas in the oven. The DM came to the serving line, at that time and instructed Dietary Aide #3 to stop and wash her hands. During an interview, on 08/10/2016 at 2:28 p.m., a representative from [Name of Company] indicated a service technician visited the facility to evaluate the potential problem with the walk in freezer on 08/01/2016. She indicated the service technician had to order a part for the freezer and that part should be in on 08/11/2016, and the technician would install it at that time. A current, undated policy titled,			

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	"NUTRITION PANTRY STORAGE AND CLEANING" provided by the Director of Nursing (DON) on 08/10/2016 at 2:30 p.m., indicated, "...Responsibility: Dietary, Nursing and Housekeeping...2. Each shift is responsible for daily cleaning. 3. The dietary staff is responsible for weekly refrigerator cleaning and de-frosting, if required...5. Foods which are outdated or are not labeled and dated shall be discarded daily when cleaning. 6. medications shall not be stored in the pantry area or refrigerator...9. All foods and beverages shall be labeled with the resident's name and dated. Employee food items shall be placed in the Activity Room refrigerator or employee lounge refrigerator." A current, undated policy titled, "Hand Washing" provided by the DON on 08/10/2016 at 2:30 p.m., indicated, "...When to Wash Hands (at a minimum):...After handling any contaminated items (...garbage, ect)...." A document titled, "Handout, Personal Hygiene Procedure", dated 2010, provided by the DON on 08/10/2016 at 2:30 p.m., indicated, "Clean hands: Before handling or serving food...After handling garbage...As often as necessary to keep hands clean...."			

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	A current, undated policy titled, "Use of a Thermometer-Food" provided by the DM on 08/10/2016 at 2:30 p.m., indicated, "...PROCEDURE: 1. A clean, rinsed, and sanitized thermometer...will be used to take food temperatures. 2...Remove the thermometer from the food item and immediately clean, rinse and sanitize the thermometer. 3. Sanitize the probe thermometer with an alcohol swab between foods being checked." A current, undated policy titled, "Food Temperatures-Cooked Foods" provided by the DM on 08/10/2016 at 2:30 p.m., indicated, "...What are the Required Temperatures? Food item...Pork...Minimum Final Cooking Temperature 155 degrees or 15 seconds...What to do? Cook foods to the proper temperatures and take the temperature with a clean and sanitized probe thermometry Reheat foods in the oven and check temperatures before placing on a steam table or hot holding units...." This Federal tag relates to Complaint IN00207175. 3.1-21(a)(2) 3.1-21(i)(2) 3.1-21(i)(3)			

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