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
	155352		04/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKHART REHABILITATION CENTER	2600 MOREHOUSE AVE ELKHART, IN 46517

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F 000 Bldg. 00	This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00169180. Complaint #IN000169180 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225 & F226. Survey dates: April 13, 14, 15, 16 & 17, 2015 Facility number: 000243 Provider number: 155352 AIM number: 100289830 Census bed type: SNF/NF: 46 Total: 46 Census payor type: Medicare: 4 Medicaid: 37 Other: 5 Total: 46 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 000	This Plan of Correction constitutes Elkhart Rehabilitation Center's written allegation of compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conslusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center respectfully requests consideration for a desk review of this Plan of Correction.	

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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F 223 SS=D Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure 1 of 2 residents reviewed for abuse was free from verbal abuse by another resident. (Resident #C) Finding includes: On 4-17-2015 at 10:00 A.M., a record review of a Mood and Behavior Symptom Assessment/Plan of Care, dated 4/2/2015, for Resident #C indicated diagnosis of TBI (Traumatic Brain Injury) and mental illness. Review of all records for Resident #C indicated no documentation on or around 3-3-2015 related to an allegation of abuse. On 4-17-2015 at 10:15 A.M., a record review of current Physician orders for Resident #B indicated diagnosis of, but not limited to, Diabetic Mellitus,	F 223	It is the practice of this facility to ensure the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Facility will ensure residents will be free from verbal abuse by other residents. Residents' C and D charts to be reviewed and updated to reflect current status. Facility will continue to follow policy and procedure related to Abuse Prohibition. Resident concern reports will be reviewed for the past 30 days for any potential resident verbal abuse. The Mood and Behavior care tracker documentation will be reviewed for the past 30 days for any potential resident verbal abuse. All staff will be re-educated on the concern reporting policy. Department heads will receive re-education on following up with concern reports and reporting to Administrator immediately any	05/15/2015

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	hypertension and vascular dementia. A "Mood and Behavior Symptom Assessment/Plan of Care," dated 7-15-2014, indicated "...Verbally abusive: hx [history] of cursing/threatening peers/staff...." Review of all records for Resident #C indicated no documentation on or around 3-3-2015 related to an allegation of abuse. On 4-17-2015 at 11:40 A.M., review of a "Resident Concern Report," dated 3/3/15 at 10:45 A.M., filed on behalf of Resident #C, indicated, "Nature of concern...[Resident name-Resident #C] states Sun. [Sunday] nite about 12 midnight [Resident name-Resident #B] came into her room and told Resident #C he wanted to 'F--- her'...Resident #C states she told [Resident name-Resident #D] and [Employee name-SSD-Social Service Director]...Resident #C state he did scare her...." The concern report was completed by the Administrator and the Social Service Director interviewed Resident #B and #D. There was no more documentation to review related to the incident. On 4-17-2015 at 2:21 P.M., during an interview with the Administrator and the Corporate Nurse, the Administrator indicated, "We [Administrator and		abuse allegation. Administrator and/ or designee will report, investigate and follow up on abuse allegations. Administrator and/or designee will review daily resident concern forms. Findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one to one re-education up to and including termination. Completed by 05/15/15	

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	Corporate Nurse] have discussed this and we should have reported it [the abuse allegation]...we will be doing a late report." On 4-16-2015 at 12:39 P.M., a record review of the Abuse policy, last revised on April 2013, and received from the Administrator at this time, indicated, "...Procedure...Reporting...2. Report the incident immediately to the Administrator and DON [Director of Nursing]/designee, who will immediately report any allegations of mistreatment, neglect, abuse...to applicable state and other agencies...." This Federal tag relates to Complaint #IN00169180. 3.1-27(b)			

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F 225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is			

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	verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to an allegation of verbal abuse for 1 of 2 residents reviewed for abuse. (Resident #C) Finding includes: On 4-17-2015 at 10:00 A.M., a record review of a Mood and Behavior Symptom Assessment/Plan of Care, dated 4/2/2015, for Resident #C indicated diagnosis of TBI [Traumatic Brain Injury] and mental illness. Review of all care plans for Resident #C indicated no update on 3-3-2015. On 4-17-2015 at 10:15 A.M., a record review of current Physician orders for Resident #B indicated diagnosis of, but not limited to, Diabetic Mellitus, hypertension and vascular dementia. A "Mood and Behavior Symptom Assessment/Plan of Care," dated 7-15-2014, indicated "...Verbally abusive: hx [history] of cursing/threatening peers/staff...." Review of all care plans for Resident #C indicated no update on 3-3-2015. On 4-17-2015 at 11:40 A.M., a record review of a "Resident Concern Report,"	F 225	It is the practice of this facility to ensure all alleged violations involving mistreatments, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. Facility will ensure alleged allegations are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. Alleged allegation was reported and reviewed by the annual surveyors. Facility will continue to follow policy and procedure related to Abuse Prohibition. Resident concern reports will be reviewed for the past 30 days for any potential resident verbal abuse. The Mood and Behavior care tracker documentation will be reviewed for the past 30 days for any potential resident verbal abuse. Staff will be re-educated on the concern reporting policy. Department heads will receive re-education on following up with concern reports and reporting to Administrator immediately abuse allegation. Administrator will report, investigate and follow up on abuse allegations. Administrator and/or designee	05/15/2015

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	dated 3/3/15 at 10:45 A.M., filed on behalf of Resident #C, indicated, "Nature of concern...[Resident name-Resident #C] states Sun. [Sunday] nite about 12 midnight [Resident name-Resident #B] came into her room and told Resident #C he wanted to 'F--- her'...." On 4-17-2015 at 2:21 P.M., an interview with the Administrator indicated, "We [Administrator and Corporate Nurse] have discussed this and we should have reported it...we will be doing a late report." On 4-16-2015 at 12:39 P.M., a record review of the Abuse policy, last revised on April 2013, and received from the Administrator at this time, indicated, "...Procedure...Reporting...2. Report the incident immediately to the Administrator and DON [Director of Nursing]/designee, who will immediately report any allegations of mistreatment, neglect, abuse...to applicable state and other agencies...." This Federal tag relates to Complaint #IN00169180. 3.1-28(a)		will review daily resident concern forms. Findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one to one re-education up to and including termination. Completed by 5/15/15	

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F 226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement the facility policy by not reporting an allegation of verbal abuse for 1 of 2 residents reviewed for abuse. (Resident #C) Finding includes: On 4-17-2015 at 10:00 A.M., a record review of a Mood and Behavior Symptom Assessment/Plan of Care, dated 4/2/2015, for Resident #C indicated diagnosis of TBI [Traumatic Brain Injury] and mental illness. Review of all care plans for Resident #C indicated no update on 3-3-2015. On 4-17-2015 at 10:15 A.M., a record review of current Physician orders for	F 226	It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Facility will ensure alleged allegations are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. Alleged allegation was reported and reviewed by the annual surveyors. Facility will continue to follow policy and procedure related to Abuse Prohibition. Resident concern reports will be reviewed for the past 30 days for any potential resident verbal abuse. The Mood and Behavior care tracker	05/15/2015

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	Resident #B indicated diagnosis of, but not limited to, Diabetic Mellitus, hypertension and vascular dementia. A "Mood and Behavior Symptom Assessment/Plan of Care" care plan dated 7-15-2014, indicated "...Verbally abusive: hx [history] of cursing/threatening peers/staff...." Review of all care plans for Resident #C indicated no update on 3-3-2015. On 4-17-2015 at 11:40 A.M., a record review of a "Resident Concern Report," dated 3/3/15 at 10:45 A.M., filed on behalf of Resident #C, indicated, "Nature of concern...[Resident name-Resident #C] states Sun. [Sunday] nite about 12 midnight [Resident name-Resident #B] came into her room and told Resident #C he wanted to 'F--- her'...." On 4-17-2015 at 2:21 P.M., an interview with the Administrator indicated, "We [Administrator and Corporate Nurse] have discussed this and we should have reported it...we will be doing a late report." On 4-16-2015 at 12:39 P.M., a record review of the Abuse policy, last revised on April 2013, and received from the Administrator at this time, indicated, "...Procedure...Reporting...2. Report the incident immediately to the		documentation will be reviewed for the past 30 days for any potential resident verbal abuse. Staff will be re-educated on the concern reporting policy. Department heads will receive re-education on following up with concern reports and reporting to Administrator immediately abuse allegation. Administrator will report, investigate and follow up on abuse allegations. Administrator and/or designee will review daily resident concern forms. Findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one to one re-education up to and including termination. Completed by 5/15/15	

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	Administrator and DON [Director of Nursing]/designee, who will immediately report any allegations of mistreatment, neglect, abuse...to applicable state and other agencies...." This Federal tag relates to Complaint #IN00169180. 3.1-28(a)			
F 241 SS=E Bldg. 00	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. A. Based on observation, interview and record review, the facility failed to ensure urinary catheter bags were covered to ensure resident dignity was maintained for 2 residents observed with urinary catheters. (Resident #12 and Resident #14) B. Based on observation, interview and record review, the facility failed to address residents that need assistance with eating in a respectful way for 5 of 5	F 241	It is the practice of this facility to maintain environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. Staff re-educated on the need to maintain an environmental of dignity and respect ensuring catheter bags are covered for residents observed to have urinary catheters and to address in respectful way residents eating in the assisted dining room. Residents residing in the facility	05/15/2015

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	residents observed in the assisted dining room. (Resident #2, #11, #12, #45 and #46) Findings include: A.1. On 4-13-15 at 6:45 P.M., Resident #14 was observed laying in bed with a urinary catheter bag hanging, uncovered, on the frame of his bed. The catheter drainage bag was observed with yellow liquid in it. On 4-13-15 at 6:47 P.M., Resident #12 was observed laying in bed with a urinary catheter bag hanging, uncovered, on the frame of his bed. The catheter drainage bag was observed with yellow liquid in it. On 4-14-15 at 7:00 A.M., Resident #12 was observed laying in bed with a urinary catheter bag hanging, uncovered. on the frame of his bed. The catheter drainage bag was observed with yellow liquid in it. On 4-16-15 at 3:28 P.M., Resident #12 was observed laying in bed with a urinary catheter bag hanging, uncovered, on the frame of his bed. The catheter drainage bag was observed with yellow liquid in it. An interview with the DON (Director of Nursing) was conducted at this time. The DON indicated catheter bags should be covered.		with urinary catheters will be audited for catheter bags coverage and residents observed eating in the assist dining room will be addressed by following policy and procedure and re-education and/or disciplinary action of employees whom are found to not follow policy. Staff will be re-educated on maintaining an environment of respect with covering urinary catheters and respectfully addressing residents in the assist dining room. DON/ and or designee will monitor urinary catheters for coverings/and how staff address residents in assist dining rooms daily (Monday through Friday) for 2 weeks and then weekly for two months, then twice a month for one month and then monthly for three months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by 5/15/15	

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	On 4-17-15 at 3:00 P.M., an interview with the Corporate Nurse was conducted. The Corporate Nurse indicated they did not have a policy related to catheter care or the covering of the drainage bags. B.1. On 4-14-2015 at 8:38 A.M., an interview was conducted with LPN (Licensed Practical Nurse) #20 related to Resident #58 and her untouched dinner tray on her bedside table. LPN #20 indicated, "She doesn't feed herself, they feed her in her room...she doesn't go down to the feeder room." On 4-16-2015 at 7:47 A.M., an observation was made of Resident #11 and #45 being transferred from their beds to their wheelchairs. LPN #20 came into their room and indicated, "I am just checking on the feeders." On 4-16-2015 at 9:39 A.M., an interview with CNA (Certified Nursing Assistant) #21, while in the presence of Resident #11 and #45, indicated, "I am rarely in the feeders room." On 4-17-2015 at 2:12 P.M., an interview with the Director of Nursing indicated that was not acceptable. 3.1-3(t)			

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F 242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to provide desired shower times and oral care for 2 of 3 residents who require assistance with showers and oral care. (Resident #11 and Resident #53) Finding includes: 1. On 4-14-2015 at 10:30 A.M., an observation was made of Resident #11. Resident #11 was found to have hair that was uncombed, food in her teeth and dry lips. On 4-14-2015 at 10:46 A.M., during an interview, Resident #11 indicated, "I would like 2 showers a week but I do not get them...I get bed baths...they do not ask me what I would like to do, they just give me a bed bath...I can not remember the last time my teeth were brushed...I	F 242	It is the practice of this facility to choose activities, schedules, and health care consistent with his/her interests, assessments, and plans of care. Residents #11 and #53 will be assessed for residents choose of shower/bed bath schedule and oral schedule. Care Plans and CNA sheets will be updated to reflect residents choose and current status. Residents residing in facility will be assessed for shower/bath type schedule and oral schedule. Care plans and CNA sheets will be updated to reflect residents choose and current status. Staff will be re-educated on providing residents chooses with shower/bath type schedule and oral schedule and providing documentation. DON/ and or designee will monitor shower/bath type	05/15/2015

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	would like them brushed at least once a day but twice would be nice." On 4-14-2015 at 3:10 P.M., during an interview, CNA #26 indicated, "...I give her [Resident #11] a bed bath every night...her shower days are Wednesday and Saturday nights...she can not brush her teeth by herself...I brush her teeth every night...." On 4-16-2015 at 9:10 A.M., a record review was conducted of Resident #11's ADL (Activities of Daily Living)/Mobility: Plan of Care, dated 3-20-2015, and indicated, "...Potential or Actual ADL/Mobility deficit r/t [related to]...Arthritis, MS [Multiple Sclerosis] and Schizophrenia...Goal...Will be neat, clean and well groomed daily...Interventions...Assist/encourage/provide per resident preference:...Shower...Provide oral care daily and PRN [as needed or desired]...physical assist...." The "Bath Type Detail Report" for Resident #11 indicated 3 out of a possible 8 showers had been given during the time period of 3-17-2015 to 4-15-2015. The MDS (Minimum Data Set) assessment for Resident #11 indicated a BIMS (Brief Interview for Mental status) score of 11/15, cognitively intact. A "Quarterly Nursing Data Collection and		schedules and oral scheduled daily (Monday through Friday) for 2 weeks and then weekly for two months, then twice a month for one month and then monthly for three months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by 5/15/15	

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	155352		04/17/2015

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	Assessment," dated 3-5-2015, indicated, "...Personal Hygiene: Total Dependence...Bathing: Total Dependence...." On 4-16-2015 at 9:44 A.M., CNA #23 indicated, "I did oral care while I was getting her [Resident #11] dressed this morning. I didn't use a toothbrush, I used an oral swab." On 4-16-2015 at 9:50 A.M., Resident #11 indicated no oral care was done for her that morning. On 4-17-2015 at 2:27 P.M., during an interview, the Director of Nursing indicated, "...I would expect they [the staff] would go in and say, it's time for your shower...the choice should be hers...I would expect Resident #11 to have her teeth brushed twice a day with a toothbrush, not an oral swab...." 2. On 04/14/2015 at 10:37 A.M.,during an interview, Resident #53 indicated the CNAs (Certified Nursing Assistants), do not ask if she wants a shower on her shower days, and they tell her they are going to give her a bed bath. The resident indicated she has to be moved with the Hoyer lift and it takes 2 CNAs and they do not like to use the Hoyer. The resident indicated she would like to have			

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	more than 2 showers a week, but has never been asked. On 04/16/2015 at 12:21 P.M., an interview with CNA #22 was conducted. CNA #22 indicated if a resident refuses a shower/bath/bedbath, she asks the resident later if they would like a shower. If the resident refuses again, she will notify the Nurse. CNA #22 indicated Resident #53 has not refused showers or bed baths, and most frequently gets a bed bath. On 04/16/2015 at 1:30 P.M., an interview with CNA #23 indicated any time a shower or bath is given, it should be charted in the computer under ADLs (Activities of Daily Living). When the entry, "Scheduled -but provided on other shift," was documented, the record of the shower or bath should have been documented on the shower sheet. On 04/17/2015 at 2:07 P.M., an interview with the Corporate Nurse indicated the CNAs should always ask the resident if they prefer a shower or a bed bath. On 04/17/2015 at 2:16 P.M., Resident #53 indicated she has only had one shower since admission. Resident indicated she has never refused a shower and no one asked what her preference			

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	was on admission. Resident #53 indicated the CNAs never asked her if she wanted a shower or bed bath on shower days. On 04/17/2015 2:27 P.M., an interview with LPN #24 was conducted. LPN #24 indicated it was the Activity Directors' responsibility to document resident shower/bath/bedbath preferences, but there was no documentation of preferences because they do not currently have an Activities Director on staff. On 04/17/2015 at 3:09 P.M., Resident #53's record was reviewed. The most current MDS (Minimum Data Set) assessment, dated 02/24/2015, indicated diagnoses included but were not limited to hypertension, CVA (cerebrovascular accident), seizure disorder, and depression. The MDS indicated a BIMS (Brief Interview of Mental Status) of 13/15, cognitively intact. The MDS indicated preferences regarding choices of shower, bath, or bedbath were very important to the resident. The care plans included, but were not limited to, ADLs (Activities of Daily Living), with the intervention to, "Assist/encourage/provide per resident preference: shower/bed bath with 1 assist."			

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	The ADL record titled, "Bath Type Detail Report," indicated the resident received 9 bed baths and 4 showers from 3/17/2015 to 4/15/2015. The shower schedule indicated Resident #53 should have a shower or bath every Tuesday and Friday on day shift. 3.1-3(u)(1)			
F 248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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. Based on observation, interview and record review, the facility failed to ensure an ongoing program of activities were implemented to ensure engagement of 1 resident reviewed for activities. (Resident #58) Finding includes: On 4-13-15 at 6:45 P.M., Resident #58 was observed laying in her bed in her dark room with her eyes open.	F 248	It is the practice of this facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. Resident #58 chart reviewed and updated for activity needs to reflect current status. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy.	05/15/2015

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	On 4-14-15 at 10:29 A.M., Resident #58's record was reviewed. Her diagnoses included but were not limited to: neck mass, basal cell carcinoma, squamous cell cancer of neck, dementia, non-insulin dependent diabetes mellitus. A MDS (Minimum Data Set) assessment, dated 3-3-15, indicated her BIMS (Brief Interview for Mental Status) could not be completed due to her advanced dementia. An Activity Progress Note, dated 3-30-15, indicated "...Resident's structured leisure pursuits include (favorite activities, special accomplishments, and/or new interest): special events, exercise, friendly visits, crafts...Detail problem information: Needs encouragement and assistance...." Review of Activity Pursuit Care Plan, dated 4/2/15, indicated "...Problem/Strength:...Activity Preferences:...Listen to music you like: church...Keep up with the news: Channel 16...Do things with groups of people: yes...Participate in religious services or practices: Christian...Activities participation limited by: cognition...Activities strength evidenced by: willing, motivated...Interventions:...Groups: church services, special events...Provide resident equipment needed to listen to music...Assist resident to group activities of interest...Ensure spiritual background		Life Enrichment Director and/ or designee will monitor residents needing one- on-one activities daily (Monday through Friday) for 2 weeks and then weekly for two months, then twice a month for one month and then monthly for three months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by 05/15/15	

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	needs are met...Provide monthly calendar for resident...Provide in room supplies for leisure...." On 4-14-15 at 2:28 P.M., Resident #58 was observed laying in her bed in her dark room with her eyes open. On 4-15-15 at 1 P.M., Resident #58 was observed laying in her bed in her dark room. At 1:45 P.M., an Elvis activity was occurring in the MDR (Main Dining Room). Resident #58 was in her bed in her room with the lights off. On 4-15-15 at 2:35 P.M., Resident #58 was observed laying in her bed in her room with the lights off. A church service activity was observed to be occurring in the MDR. On 4-16-15, Resident #58 was observed from 7:30 A.M. to 10:15 A.M. During this time the following was observed: 7:30 A.M.- Laying in her bed on her right side, room lights were off. Resident #58's TV was on but half covered by privacy curtain. 8:15 A.M.- Breakfast room tray was removed from room without resident eating due to her sleeping. 8:40 A.M.- CNA (Certified Nursing Assistant) #17 entered Resident #58's room, called her name several times			

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	before walking out, "...I'll leave her alone." 9:15 A.M.- Resident #58 was observed rolling over to her right side and attempting to get out of bed. CNA #18 entered her room with CNA #17 to assist resident up to bathroom to get washed up and dressed for the day. CNA #17 indicated "...She's declined so much recently, I think if they got her a wheelchair she could get up and go to the dining room and go to activities. She used to be able to go when she could walk. Now she can't...She got real bad about a month ago...She just stays in her bed all the time...." After washing up Resident #58, CNA #17 and CNA #18 assisted her back to lay in her bed. On 4-16-15 at 12:00 P.M., Resident #58 was observed laying in her bed in her room, the room lights remained off. On 4-17-15, from 8:42 A.M. to 11:55 A.M., Resident #58 was observed laying in her bed, in her dark room. TV was on but half covered by privacy curtain and sound was muted. On 4-17-15 at 3:00 P.M., an interview was conducted with the Administrator. The Administrator indicated they did not currently have an activity director on staff. The staff would take turns running			

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	the group activities. The Administrator indicated they keep activity attendance records on each resident and write in any extra activities the resident does. On 4-17-15 at 4:00 P.M., review of Resident #58's activity attendance records for March & April of 2015, received at this time from the Corporate Nurse, indicated no organized activities were highlighted as attended. The following dates had information written in as an activity: 3-1: slept a lot 3-4: sleeps a lot, likes cookies 3-8: slept a lot today 3-10: may walk around, sleeps a lot 3-12: up asking for candy 3-14: sleeps a lot 3-16: in bed a lot 3-17: slept 3-19: sleeping a lot 3-21: ate in room 3-23: son visit 3-24: sleeps a lot 3-29: sleeps a lot 3-31: loves cookies 4-1: slept a lot 4-4: walks up and down hall 4-7: sleeps a lot 4-9: loves cookies 4-12: slept 4-14: sleeps most of day			

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	3.1-33(a)			
F 279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to ensure that a care plan was developed related to the use of splints for 1 of 2 residents reviewed for range of motion. (Resident #2) Findings include: On 4/14/15 at 3:00 P.M., Resident #2	F 279	It is the practice of the facility to develop a comprehensive care plan for each resident. Resident # 2 chart was reviewed and care plans were updated to reflect need for use of splints for range of motion. Residents on restorative programs reviewed and care plans updated to reflect restorative programs residents currently participating. Restorative Champion will be	05/15/2015

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	was observed up in the assisted dining room with bilateral splints on hands. On 4/16/15 at 9:13 P.M., the clinical record was reviewed for Resident #2. Diagnosis include but not limited to: quadriplegic infantile cerebral palsy. The Scheduled Programs Report indicated "...Splints or Brace program : Goals 1. Resident will tolerate splint placement applied to bilateral hands up to four hours daily...." Review of care plans for Resident #2 showed no documentation that a care plan was developed for the use of bilateral hand splints. During an interview on 4/16/15 at 9:50 A.M., RN (Registered Nurse) #13 indicated Resident #2 wears her splints in the evenings. During an interview on 4/16/15 at 10:08 A.M., the DON (Director of Nursing) indicated if a resident has splints they should have orders and a care plan for them. On 4/16/15 at 3:00 P.M., the DON indicated they did not have a care plan for splints for Resident #2. On 4/17/15 at 10:00 A.M., review of the current policy "Care Plans," last updated March 2015, received from the		re-educated on updating care plans with changes to residents' restorative programs. Interdisciplinary team will review physician orders, ensuring residents care plans reflect residents current status. Residents participating in restorative programs will be reviewed during comprehensive care plan review meeting, ensuring programs reflect residents current care plans. **The DON/designee** will monitor restorative programs daily (Monday through Friday) for 2 weeks and then weekly for two months, then twice a month for one month and then monthly for three months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination.Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by 05/15/15	

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	Administrator on 4/14/15 at 12:37 P.M., indicated " ... Develops and implements an interdisciplinary care plan based on the assessment information gathered... 1. Initiate the appropriate Care Plan...." 3.1-35(b)(1)			
F 280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to revise a care plan after a fall 1 of 4 residents reviewed for accidents. (Resident #50) Finding includes:	F 280	It is the practice of the facility to revise a care plan after a fall. Resident ##50 chart was reviewed and care plans were updated to reflect current status including falls and interventions. Residents residing in facility will	05/15/2015

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	During an interview on 4/14/15 at 10:22 A.M., the DON (Director of Nursing) indicated Resident #50 fell two to three weeks ago. On 4/15/15 at 1:08 P.M., the clinical record was reviewed for Resident #50. A progress note, dated 3/31/15 at 2:00 P.M., indicated Resident #50 was found on floor next to bed, sitting on bottom on top of floor mat. The "Fall /Injury Assessment: Prevention and Management" care plan, dated 3/17/15, did not document any updates after the fall on 3/31/15. During an interview on 4/16/15 at 10:12 A.M., the DON indicated when a resident falls the care plan should be updated. On 4/17/15 at 10:00 A.M., review of the current policy "Care Plans," last updated March 2015, received from the Administrator on 4/14/15 at 12:37 P.M., indicated "...Re-evaluates the residents status at prescribed intervals, quarterly, annually, or if a significant change in status occurs...." 3.1-35(d)(2)(b)		be assessed for falls and interventions in past 60 days. Care plans and CNA sheets will be updated to reflect residents current status. Licensed nurses will be re-educated regarding Falls program and policy including updating care plan with intervention. DON/ and or designee will falls daily (Monday thru Friday) and incident taken through daily clinical review for review. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by 05/15/15	

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F 282 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 observation, interview, and record review, the facility failed to ensure physician orders were followed related to medication administration for 1 of 3 residents observed for medication pass. (Resident #46) Finding includes: On 04/16/2015 at 9:00 A.M., during a medication administration pass observation, RN (Registered Nurse) #6 removed an Exelon (Antni-Alzheimer drug) 13.3 mg (milligrams)/24 hour patch from Resident #46, dated 04/16/2015. RN #6 then administered a new Exelon 13.3 mg/24 hour patch. RN #6 looked at the residents' back again and found another Exelon 13.3mg/24 hour patch, dated 04/13/2015, and removed it. On 04/16/2015 at 10:04 A.M., during an interview, RN #6 indicated she removed 2 (two) Exelon patches from the resident during medication administration and there should have been only 1 patch to remove. She indicated the previous nurse either missed removing the patch dated	F 282	It is the practice of the facility to ensure physician orders are followed related to medication administration.Resident #46 was assessed for any changes related to the above alleged practice. Physician notified and new orders given to monitor, with no negative outcomes observed. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. Licensed nurses to be re-educated on medication administration.DON/ and or designee will review MAR/TAR with spot checks to ensure removal of patches to residents receiving patches daily (Monday through Friday) for 2 weeks and then weekly for two months, then twice a month for one month and then monthly for three months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education with repeat non-compliance resulting in disciplinary action per policy. Any	05/15/2015

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	04/13/2015, or thought the patch had fallen off. On 04/17/2015 at 4:00 P.M., the clinical record for Resident # 46 was reviewed. The diagnosis included but was not limited to, Alzheimer's, Parkinson's disease, and COPD (chronic obstructive pulmonary disease). The physician orders, dated 03/04/2015, indicated to add Exelon 13.3 mg/24 hour patch, place site on MAR (Medication Administration Record), and alternate sites and to remove the old Exelon patch. 3.1-35(g)(2)		identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.Completed by May 15, 2015	
F 312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide the desired shower and oral care for 1 of 3 residents who require total assistance with showers and oral care. (Resident #11) Finding includes:	F 312	It is the practice of the facility to ensure that residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #11 will be re-interviewed for preferences and care plans to ensure reflective of	05/15/2015

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	On 4-14-2015 at 10:30 A.M., an observation was made of Resident #11. Resident #11 was found to have hair that was uncombed, food in her teeth and dry lips. On 4-14-2015 at 10:46 A.M., during an interview, Resident #11 indicated, "I would like 2 showers a week but I do not get them...I get bed baths...they do not ask me what I would like to do, they just give me a bed bath...I can not remember the last time my teeth were brushed...I would like them brushed at least once a day but twice would be nice." On 4-14-2015 at 3:10 P.M., during an interview, CNA #26 indicated, "...I give her [Resident #11] a bed bath every night...her shower days are Wednesday and Saturday nights...she can not brush her teeth by herself...I brush her teeth every night...." On 4-16-2015 at 9:10 A.M., a record review was conducted of Resident #11's ADL (Activities of Daily Living)/Mobility: Plan of Care, dated 3-20-2015, and indicated, "...Potential or Actual ADL/Mobility deficit r/t [related to]...Arthritis, MS [Multiple Sclerosis] and Schizophrenia...Goal...Will be neat, clean and well groomed daily...Interventions...Assist/encourage/pr		current status. Resident bath type detail to be reviewed daily during morning meetings by DON/or designee. Nursing staff will be re-educated on providing ADL care and documentation. Residents residing in the facility will be reviewed for ADL care and bath type and will be addressed by following policy and procedure and re-educated and/ or disciplinary action of employees will be addressed by following policy. Nursing staff will be re-educated on providing ADL care and documentation per policy. The DON and/or designee will review bath detail reports daily (Monday through Friday) and nursing documentation for any refusal of showers. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and / or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by 05/15/15	

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	ovide per resident preference:...Shower...Provide oral care daily and PRN [as needed or desired]...physical assist...." The "Bath Type Detail Report" for Resident #11 indicated 3 out of a possible 8 showers had been given during the time period of 3-17-2015 to 4-15-2015. The MDS (Minimum Data Set) assessment for Resident #11 indicated a BIMS (Brief Interview for Mental status) score of 11/15, cognitively intact. The "Quarterly Nursing Data Collection and Assessment," dated 3-5-2015, for Resident #11, indicated, "...Personal Hygiene: Total Dependence...Bathing: Total Dependence...." On 4-16-2015 at 9:44 A.M., CNA #23 indicated, "I did oral care while I was getting her [Resident #11] dressed this morning. I didn't use a toothbrush, I used an oral swab." On 4-16-2015 at 9:50 A.M., Resident #11 indicated no oral care was done for her that morning. On 4-17-2015 at 2:27 P.M., during an interview, the Director of Nursing indicated, "...I would expect they [the staff] would go in and say, it's time for your shower...the choice should be hers...I would expect Resident #11 to			

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	have her teeth brushed twice a day with a toothbrush, not an oral swab...." 3.1-38(a)(3)(B) 3.1-38(a)(3)(C)			
F 323 SS=G 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, record review and interview, the facility failed to transfer a dependent resident with the required lift which resulted in a distal humerus fracture that required surgery for 1 of 4 residents reviewed for accidents. (Resident #45) Finding includes: On 4-14-2015 at 7:00 A.M., an observation was made of Resident #45 being fed breakfast in the assisted dining room. Resident #45 was in a wheelchair with a high backed head support. Resident #45 was able to move her left hand but unable to pick up her glass or silverware.	F 323	**F 323** It is the practice of this facility to ensure a safe environment for each resident related to lift transfers. Resident #45 chart reviewed to ensure care plans reflective of current status. This incident was a facility self report to state per guidelines. Residents who reside in the facility have potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. Residents requiring lifts will be re-assessed for appropriateness with care plans / CNA sheets reviewed to reflect current status. Nursing staff will be re-educated on ensuring environment remains as	05/15/2015

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	On 4-14-2015 at 10:30 A.M., a review of the clinical record for Resident #45 was conducted. Resident 45's diagnoses included, but were not limited to, diabetes mellitus, dysphagia, hypertension, mental retardation, obesity, Parkinson's disease. The History and Physical, dated 11-12-2014, indicated, " ...X-ray showed distal one-third displaced humerus fracture...she [Resident #45] is unable to get up on her own and or ambulate...Assessment and Plan:..1. Right complete displaced oblique fracture distal humeral shaft...Plan will be...surgical stabilization in one to two days...." On 4-14-2015 at 3:10 P.M., an observation of Resident #45 in her room and in her bed was conducted. Resident #45 used her left hand to move her right hand over her body. An interview was attempted at this time related to the injury to her right arm but Resident #45 was unable to recall the incident or the reason why she cannot move her right arm. On 4-15-2015 at 1:15 P.M., a review of an Incident Report Form, dated 11-13-2014, and received from the Administrator at this time, related to a fracture to a dependent resident during transfer for Resident #45, indicated, "...Brief Description of Incident...		free of accident hazards as is possible for each resident and lift use. DON/ or designee will monitor appropriate transfer/lifts used daily (Monday through Friday) for 2 weeks and then weekly for two months, then twice a month for one month and then monthly for three months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education with repeat non-compliance resulting in disciplinary action per policy. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by May 15, 2015	

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	[Resident name-Resident #45] was sitting on the side of her bed. CNA [Certified Nursing Assistant] #7 and CNA #8 were putting her to bed. CNA #7 placed her right hand under resident's right leg and placed her left hand behind resident's neck, pivoted resident toward the right and laid resident down. Resident then complained that her right shoulder was hurting. CNA #7 summoned LPN [Licensed Practical Nurse] #11, who then summoned LPN #12. The resident was assessed. The resident was unable to move her right arm freely without pain. Resident told the nurse that it popped during her transfer earlier in the day when the Restorative Aid, CNA #9 transferred her...The resident was then sent to the E.R. [Emergency Room] at [local hospital]. X-rays demonstrated complete displaced oblique fracture to the right distal humeral shaft with marked displacement...." A "Witness Investigation Statement", dated 11-12-14 at 6:30 P.M., indicated, "Witness Name: [CNA name-CNA #7]...I with assist from [CNA #8] went to lay [Resident name-Resident #45] down for bed. We used the Sit to Stand lift [a lift used for a person who can bear weight] to transfer her. She [Resident #45] didn't complain of any pain until after she was layed in bed. She [Resident #45] had			

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	stated to me that she felt her right shoulder pop. I myself heard no pop." A CNA assignment sheet, dated 11-12-2014, indicated Resident #45 as a "Dependent lift for transfer-hoyer [a lift used for a person who can not bear weight]." An interview with the Administrator was conducted on 4-17-2015 at 2:12 P.M. The Administrator indicated that CNA #9 was dismissed because during the investigation, CNA #9 indicated that she used the Sit to Stand lift for Resident #45 because it was easier for her (CNA #9) to transfer her instead of the ordered hoyer lift. 3.1-45(a)(2)			

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F 356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review, the facility failed to post the updated actual hours worked per shift on the Daily Nurse Staffing Form for 5 of 5 days the posting was observed. (4-13,	F 356	It is the practice of this facility to post the nurse staffing information on a daily basis. No resident was harmed by this practice. Residents who reside in the	05/15/2015

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	4-14, 4-15, 4-16 and 4-17-2015) Finding includes: The "Daily Nurse Staffing Form" was observed and reviewed during the 5 days of the survey (4-13, 4-14, 4-15, 4-16 and 4-17-2015). The posting included the total number of RN's (Registered Nurses), LPN's (License Practical Nurses), and CNA's (Certified Nursing Assistants). Under the column for "Actual Hours Worked", the posting was completely filled out for all shifts, current and future, for the day. On 4-17-15 at 4:33 P.M., an interview with the ADON (Assistant Director of Nursing) was conducted. The ADON indicated "...the night shift nurse will fill it out at midnight for the next day, she takes call offs for the day shift if there are any...she fills it out for the entire day, until the next night shift...."		facility have potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. Nurse management will be re-educated on the specifics to be posted on the nurse staffing information form daily. Administrator and/or designee will monitor daily (Monday through Friday). Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Completed by 05/15/15	
F 364 SS=E Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.			

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	A. Based on observation, interview and record review, the facility failed to serve food trays at the proper temperature at point of service. This had the potential to affect 25 residents that received trays on the North Hall, South Hall, and Assisted Dining Room. B. Based on observation and interview the facility failed to ensure food that was prepared conserved the nutritive value related to pureed food preparation related to 8 of 8 pureed meals prepared. Findings include: A.1. On 4-14-15 at 2:02 P.M., Resident #35 indicated he eats in his room and the food on his tray arrives cold. During an observation on 4-16-15 from 7:31 A.M. to 8:15 A.M., the following was observed: *The South Hall meal trays arrived at 7:31 A.M. The last tray was served at 8:00 A.M. The toast with butter was at 75 degrees Fahrenheit (F) and the milk was at 52 degrees F. *The Assisted Dining Room meal trays arrived at 7:35 A.M. The last tray was passed at 8:01 A.M. The cream of wheat was at 123 degrees F, the french toast	F 364	**F364** It is the practice of this facility to serve food trays at proper temperatures at point of service and preparing nutritive value related to pureed food. Residents receiving hall trays on North/South and the assisted dining room were potentially affected by the practice improper temperatures. Residents receiving pureed meals had the potential to be affected by this practice. Residents who reside in the facility have potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. Staff will be re-educated on the need to serve food trays to ensure proper temperatures at point of service. Dietary cooks will be re-educated on preparing pureed meals per policy and procedure on how to replace broken items/equipment.. Staff members are to notify the appropriate Department Head of any broken items to be communicated to the Administrator who will determine if the item can be fixed or replaced. All items are to be either fixed or replaced within a reasonable time frame. Dietary Manager will monitor food temperatures at the point of service and monitor preparation of pureed meals and equipment daily (Monday through Friday) for 30 days, then 3 times a week for	05/15/2015

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	with syrup was 105.5 degrees F, and the sausage patty was 105 degrees F. *The North Hall meal trays arrived at 7:45 A.M. The last tray was served at 8:10 A.M. The french toast was at 78 degrees F, the sausage patty was at 82 degrees F, the milk was at 52 degrees F. At this time, the DM indicated milk should be served under 42 degrees F, and hot food should be over 135 degrees F. On 4-16-15 at 1:17 P.M., review of the current "Food Temperature Record" policy, received from the Administrator at this time and last updated in October 2014, indicated "...The minimum safe serving temperature is 135 degrees...Milk holding temp [temperature] below 41* [degrees]...." B.2. On 4/14/15 at 9:15 A.M., during pureed meal preparation the following was observed: Cook #4 was observed adding a unmeasured amount of, diced ham, sliced bread and ham juice into puree machine bowl. Blending it then placing it into a pan. At this time, Cook #4 indicated "...we just use what is left over after feeding our regulars... I don't follow a recipe... I've been here for 4 years I just know the recipes... no we don't have a pureed ham recipe...." Cook #4 then placed a unmeasured amount of		1 month, and then once a week for 1 month and then monthly. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/ or further monitoring needs. Administrator will spot check one tray per week and forward results through QA for further needs. Identified non-compliance will result in one on one re-education with repeat non-compliance resulting in disciplinary action per policy. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Incorrect food temperatures will be noted in which case re-education, investigation and additional monitoring will occur. Completed by May 15, 2015	

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	beets and 4 slices of bread into the puree machine bowl, pureed it then poured it into a pan. On 4/14/15 at 9:35 A.M., the Dietary Manager provided the current recipe for pureed "Baked Ham and Harvard Beets" which indicated, "... Baked Ham ...Ham Stock ...Food Thickener... Combine water and thickener to make a slurry... Process ham and slurry until desired consistency.. Diced Beets ... Drain beets reserve juice for sauce ... Salt... Sugar...Cornstarch... Combine dry ingredients add to beet juice... Margarine... Vinegar... Add margarine and vinegar stir until mixed and margarine is melted... heat beets add sauce...." During an interview on 4/14/15 at 10:03 A.M., the Dietary Manager indicated, "Yes, they should follow the recipe." 3.1-21(a)(1) 3.1-21(a)(2)			
F 371 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			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	under sanitary conditions Based on observation, interview and record review, the facility failed to store and serve food under sanitary conditions in regards to proper use of hairnets, insufficient handwashing, and food service. This had the potential to effect 45 of 45 resident receiving meals from 1 of 1 kitchen. Findings include: 1. On 4/13/15 from 6:30 P.M., to 7:00 P.M., during the initial tour of the kitchen accompanied by Dietary Aide #16, the following was observed: At 6:40 P.M., In the dry storage: * A 25 pound bag of semi sweet chocolate chips, open to air. Dietary Aide #16 indicated at this time "...I guess this should be closed...." * A 7-1/4 oz. (ounce) dented can of Campbell's Chicken Noodle soup. Dietary Aide #16 indicated at this time "...I don't know what we do with those...." At 6:45 P.M., in the walk in cooler: * An open, undated, 1/2 gallon of True Moo Chocolate Milk. * An open, undated, 1/2 gallon of 2% milk. The Dietary Manager indicated at this time "...I don't know how you would	F 371	It is the practice of this facility to prepare and serve in sanitary conditions in regards to hand-washing, improper use of hairnets and food service. Staff will be re-educated on the appropriate hand-washing technique, hairnet use while preparing and serving residents and food storage. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. Staff re-educated on appropriate hand-washing techniques, use of hairnets and storing food. The DON, dietary manager, and /or designee will monitoring dining room for hand-washing techniques and hairnet use daily and food storage daily (Monday through Friday) for 2 weeks, 3 times per week for 2 weeks, weekly for 2 months and then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/ or further monitoring needs. Identified non-compliance will result in one on one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.	05/15/2015

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	tell when these have been opened...." At 6:50 P.M., in the walk in freezer: *A 29.7 pound box of Southern Style biscuits, undated, open to air. On 4/13/15 at 7:30 P.M., the ice machine in the main dining room was observed to have a crusty gray film on the front of the machine. Water was dripping into catch basin, then dripping onto counter then dripping down onto floor creating a puddle. On 4/14/15 at 7:30 A.M. Cook #4 was observed in the kitchen, serving food, wearing her hair net back off the front of her bangs. On 4/14/15 at 7:45 A.M., Cook #4 was observed to pick up a bowl with her fingers inside the bowl then fill it with with oatmeal. On 4/14/15 at 7:48 A.M., while in the kitchen, 3 trays of cereal, each containing 12 uncovered bowls we observed with no lids on stacked on on top of the other. 2. On 4/14/15 from 7:54 A.M. to 8:15 A.M., observation of the breakfast meal was conducted in the main dining room. During this time the following was observed:		Completed by 05/15/15	

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	At 7:54 A.M., the DON (Director of Nursing) was observed serving a resident chocolate milk and tomato juice by the top rim of the glass. At 7:52 A.M., Employee #19 was observed wearing her hairnet back off the front of her hair, with her bangs hanging out, serving a resident orange juice by the top rim of the glass. At 7:55 A.M., the DON was observed serving a resident a glass of orange juice by the top rim of the glass. At 7:57 A.M., the DON was observed serving a cup of coffee to resident with open palm of hand over top of cup. At 7:59 A.M., the DON was observed serving orange juice to a resident by the top rim of the glass. At 8:00 A.M., Employee #19 was observed serving apple juice to a resident by top rim of glass. At 8:04 A.M., the DON was observed to wash her hands for 12 seconds, during that time she touched the cold water faucet twice. She then picked up a glass by the top rim and filled it with apple juice and served it to a resident.			

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	At 8:05 A.M., the DON was observed to serve a glass of milk to a resident by the top rim of the glass. At 8:06 A.M., the DON was observed dragging her jacket sleeve through a residents plate of biscuits and gravy while placing a glass of cranberry juice in front of the resident. At 8:07 A.M., the DON was observed serving a resident a glass of apple juice with the open palm of her hand over the top of glass. At 8:08 A.M., Employee #19 was observed serving a bowl of fruit loops to a resident with her thumb on inside edge. At 8:13 the DON was observed to wash her hands for 4 seconds then serve a resident a glass of orange juice. On 4/14/15 at 9:15 A.M., during the puree preparation observation, Cook #4 was observed to make pureed ham, wash puree bowl, wipe off counter, then go onto make pureed beets without washing hands. On 4/14/15 at 9:35 A.M., Cook #4 was observed licking finger then paging though recipe book, pulled out recipe for			

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	pureed beets, then went on to place desserts on plates, without washing hands. During an interview on 4/14/15 at 10:15 A.M., the DM (Dietary Manager) indicated that dented cans should be pulled from the shelf and put in my office for credit. Any food that is opened should be dated and sealed. During an interview on 4/17/15 at 4:04 P.M., the DM indicated that bowls should be handled from the bottom, cups by the handles, glasses by the bottom, hands should not be on the top rim or open handed over the top of the glass. On 4/16/15 at 9:23 A.M., the current policy titled, "Hand Hygiene-Plain Soap and Water" was provided by the Corporate Nurse. The policy indicated "... 6. Rub hands together vigorously for 15-20 seconds... 9. Turn off faucets with the paper towels...." On 4/16/15 at 1:17 P.M., the current policy "Serving," provided by the Administrator, indicated "... 3. Wash hands prior to serving food... a. Practice good personal hygiene by keeping hair in hairnet...5. Avoid touching food contact areas... a. Never touch food contact area of plates, bowls, glasses, or cups...b.			

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	Hold dishes by the bottom or the edge...d. Hold glassware by the middle bottom or stem... 7. Transport food in a sanitary method to prevent contamination... a. Cover or wrap food sent out to the floor or resident room...." During an interview on 4/17/15 at 9:50 A.M., the Housekeeping Manager indicated, "...the kitchen is responsible for the ice machine...I wipe it down but it is too moldy to get clean...." During an interview on 4/17/15 at 10:40 A.M., the DM indicated "...maintenance and house keeping are responsible for cleaning the ice machine...." 3.1-21(i)(2)			
F 456 SS=C Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure 1 of 1 puree machines were in safe operating condition. This had the potential to effect 8 residents who received pureed meals from the kitchen.	F 456	It is the practice of this facility to maintain puree machine in safe operating condition. A new bowl has been ordered for the food processor. Any non-approved adapted equipment has been removed from the facility. All residents on a pureed diet	05/15/2015

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	Findings include: On 4/14/15 at 9:15 A.M., during observation of puree meals in the kitchen, Cook #4 was observed placing a piece of wood in the lid/ handle of the pureed machine to make it turn on. Cook #4 indicate at this time "...the machine has been broken for a while...we have to place the wood in there to make it run...." During an interview on 4/17/15 at 4:04 P.M., the Dietary Manager indicated "...the metal piece that holds the lid in place is broken...my staff uses a piece of wood to hold it together so it runs...." 3.1-19(bb)		have the potential to be affected. All dietary staff members are to be in-serviced on the proper tools and equipment to be used in the preparation of resident food. All dietary staff will be in-serviced on pureeing food. All dietary staff will be in-service and will have to demonstrate the proper procedure to use the food processor. The Dietary Manager will monitor daily (Monday through Friday) for 4 weeks. Then 3x/week for four weeks. Completed by 05/15/15	
F 465 SS=F Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure a sanitary and comfortable environment was maintained related to cracked tile and clean floors in 2 of 2 halls. (North hall, South hall) Findings include:	F 465	**F465** it is the practice of this facility to provide a sanitary and comfortable environment related to cracked tile and clean floors. No negative outcomes. Floor tiles will be assessed for replacement. Toilets will be assessed for needed caulking. Housekeeping will place rooms on a deep cleaning schedule, along with a daily cleaning schedule.	05/15/2015

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	On 4/16/15 at 945 A.M. to 10:35 A.M., an environmental tour was conducted with the Maintenance Director and Housekeeping Manager. During the tour the following was observed: At 9:45 A.M., in Room 26 the call light cord in the bathroom measured 1-1/2 inches long and the caulking around the toilet was observed to be half present. The Maintenance Director indicated at this time "...the call light cord is a problem I will fix that right away...I only caulk the toilets if they are leaking...." During the environmental tour the tile at the entrance to Rooms 35- 29, 27- 22, 20-14, 12-5, and Room #2, were observed to be cracked. The Maintenance Director indicated at this time, "...the tile is cracked because there are three layers of tile down on top of each other...they just tile over the old floor and not pull it up...there are no plans to fix it at this time because a new company is taking us over...." At 9:50 A.M., the floor in Room 25 was observed to be dirty, under the bed there was trash and jelly beans laying on the floor. The Housekeeping Manager indicated at this time "...I am retraining my girls on how to clean the floors...."		Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. Maintenance director re-educated on corrective maintenance schedule. Housekeeping manager re-educated on need to keep resident rooms on deep clean, as well as daily clean schedule. Maintenance director will make daily rounds for any corrective maintenance, creating list of corrective items. Housekeeping will clean resident rooms daily. Housekeeping will create a rotating list of three resident rooms to complete deep clean schedule daily. Administrator and/ or designee will monitor floor tiles, toilet caulking (spot check 5 bathrooms per audit) and resident rooms (5 resident rooms per audit) daily (Monday through Friday) for 30 days, then 3 times a week for 1 month, and then once a week for 1 month and then monthly. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/ or further monitoring needs. Identified non-compliance will result in one on one re-education with repeat non-compliance resulting in disciplinary action per policy. Any identified trends will be forwarded to the administrator for review and presented to QA to determine	

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	At 10:00 A.M., the dryer lint trap in the laundry room was observed to have a large amount of lint in the trap. The form titled, "Lint Trap Cleaning Log," indicated that the form had been initialed that the lint trap had been emptied for 4/17/15. The Housekeeping Manager indicated at this time, "the lint trap should be cleaned out after each load and and documented hourly...." At 10:10 A.M., observation of the ice machine in the main dining room, indicated a crusty gray film on the front of the machine, water dripping into catch basin, then dripping onto counter then dripping down onto floor creating a puddle. The Maintenance Supervisor indicated at this time "...dietary cleans it regularly, I clean it periodically...weekly...." At 10:20 A.M., an observation of Room 19 found the wall air condition to have no on/off or temperature control or front cover. The Maintenance Director indicated at this time "...the air condition shouldn't be in pieces, theses are so old I can't get parts for them anymore...I need to get this fixed we are gong to need it soon...." Closet door and shower door scuffed across bottom. Bathroom door frame, with chipped paint and dirt in the		further educational needs. Completed by May 15, 2015	

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	corners. The Housekeeping Supervisor indicated at this time indicated "...they should be cleaning corners when doing daily cleans, I am retraining them on how to clean.... " At 10:27 A.M., in Room 9 the lock for the shower door would not turn to lock. At 10:30 A.M., the hallway tile between the activity room and the conference room was cracked. At 10: 32 A.M., the electrical panel across from activity room and the 4 electrical boxes by the main dining room were observed to be unlocked. The Maintenance Supervisor indicated at this time, "the box by the activity room is unlocked because sometimes when activities is using the oven it trips the breaker...the others are unlocked because I don't have key for them...." 3.1-19(f)			
F 514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that			

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	are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to ensure accurate and complete documentation related to Neurological Assessments after a fall for 1 of 4 residents reviewed for falls. (Resident #50) Finding includes: During an interview on 4/14/15 at 10:22 A.M., the DON (Director of Nursing) indicated Resident #50 fell two to three weeks ago. On 4/15/15 at 1:08 P.M., a clinical record review was conducted for Resident #50. Review of the Neurological Assessment Flowsheet indicated that on 3/31/15 at 9:30 P.M., 4/1/15 at 1:30 A.M., 5:30 A.M., and on the 6:00 A.M., to 2:00 P.M., shift that Neurological checks were not completed. During an interview, on 4/16/15 at 215 P.M., the Director of Nursing indicated all areas of the Neurological Assessment	F 514	It is the practice of this facility to ensure accurate and complete documentation related to neurological assessments after a fall. Resident #50 chart was reviewed and care plans are reflective of current status. Residents residing in facility will be assessed for falls and interventions in past 60 days. Care plans and CNA sheets will be updated to reflect residents choose and current status. Licensed nurses will be re-educated regarding Falls program and policy including updating care plan with intervention, including neurological assessments. DON/ and or designee will review falls daily (Monday thru Friday) and take incident through daily clinical review for review. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded	05/15/2015

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	Flowsheet should be completed after a fall no exceptions. 3.1-50(a)(2)		to the administrator for review and presented to QA to determine further educational needs. Completed by 05/15/15	