

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2016
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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with Investigation of Complaint IN00192547.</p> <p>Survey dates: February 1, 2, 3, 4, and 5, 2016</p> <p>Facility number: 000368 Provider number: 15E187 Aim number: 100275220</p> <p>Census bed type: NF: 17 Total: 17</p> <p>Census Payor type: Medicaid: 17 Total: 17</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on February 14, 2016.</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0159 SS=D Bldg. 00	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to ensure residents had access to their funds on an ongoing basis including weekends, and were able to arrange for access to larger fund amounts for 1 of 1 resident reviewed for personal funds of the 1 resident who met the criteria for personal funds. (Resident #13)</p> <p>Finding includes:</p> <p>Interview with Resident #13 on 2/1/16 at 10:31 a.m., indicated he was not able to withdraw 100 dollars from his account on the day the facility hosted an event in September, 2015.</p> <p>Review of resident's personal fund account with Social Service Designee on 2/3/16 at 10:24 a.m., indicated on 9/22/15 the resident had the amount he requested available but was disbursed \$33.00.</p> <p>Interview with the Social Service Designee on 2/3/16 at 10:24 a.m., indicated she disbursed funds to the residents Monday thru Friday, 9 am to 4</p>	F 0159	<p>F159 Based on record review and interview, the facility failed to ensure residents had access to their funds on an ongoing basis including weekends, and were able to arrange for access to larger fund amounts for 1 of 1 resident reviewed for personal funds of the 1 resident who met the criteria for personal funds. (Resident #13)</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Administration was not aware of any resident asking for funds and did not receive them. Resident #13 did not ask for additional funds prior to leaving the facility to go to the Blue Chip Casino. The administrator was present and talked to every resident prior to leaving and no concerns were expressed.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p>	03/06/2016

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	<p>pm. She indicated the funds were not available on the weekends, and if the residents needed money they would need to request it on the Friday prior to the weekend. She further indicated that she did not recall the resident asking for 100 dollars on that particular day.</p> <p>Review of (1) additional residents personal funds account with the Social Service Designee on 2/4/16 at 1:10 p.m., indicated the exact same amount (\$33.00) was disbursed on 09/22/15 to this resident, for the event hosted by the facility. She further indicated, the Activity Director had told her what amount to disburse to the (2) residents who had been able to attend the event.</p> <p>3.1-6(f)(1)</p>		<p>No one was affected because all residents who ask for their funds receive them. Residents who have PR accounts with us are informed of banking hours posted on the office window. All resident's and their family members request funds and the funds are given to them. They sign a receipt for the funds received. Quarterly statements are reviewed with each resident with a PR account.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Resident's quarterly statement will be reviewed with office manager quarterly and will sign that their statement was reviewed. Resident will also have the opportunity to review statements upon request with the social worker or social designee.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Administrator will review quarterly statement review with the residents which will be done with care conference. Office manager will provide statements and social worker will ensure signatures of review. Q.A. Committee will monitor</p>		

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			<p>statementlogs and determine if further monitoring is needed and discuss any concerns.</p> <p>ADDENDUM:The only staff members who are able to handle aresident's personal resources account is the administrator and social servicedesignee who are aware of the resident's rights to withdraw their funds thatare available in the resident's account. In this case the resident did not state to the social designee that hewanted additional funds for the trip to the Blue Chip. The procedure for resident personal resourcewithdrawal is as follows:</p> <ol style="list-style-type: none"> 1. The resident or family member request thefunds or bring in a receipt for reimbursement from the resident's funds to thesocial service designee if she is unavailable then the request is made to theadministrator. 2.A check iswritten and signed by the administrator and given to the resident and/or familymember. 3.A receipt issigned by whom the money is given to and it is kept for the facilityrecord. 4.If theresident would like cash the check is cashed by the social designee and fundsare given to the requesting party. 5. The resident's quarterly 	

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F 0167 SS=C Bldg. 00	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to post a sign indicating where the most recent survey results were located without residents and visitors having to ask for 1 of 1 survey books.</p> <p>Finding includes:</p> <p>Interview on 2/1/16 at 10:00 a.m. with the Resident Council President indicated she was unaware where the most recent Survey results were located.</p> <p>Observation on 2/1/16 at 12:40 p.m., indicated the survey book was located on a shelf under the time clock. The time clock was located to the left of the</p>	F 0167	<p>statement is reviewed by each resident and/or family member and signature of review is on the form. This will be monitored monthly for one quarter and semi-annually thereafter.</p> <p>F167 Based on observation and interview, the facility failed to post a sign indicating where the most recent survey results were located without residents and visitors having to ask for 1 of 1 survey books.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. A large sign was immediately placed at the nurses station indicating location of the survey book.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified</p>	03/06/2016	

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	<p>Nurse's station. There was no sign indicating the survey book was located under the time clock.</p> <p>Interview with the Administrator on 2/3/16 at 12:52 p.m., indicated there used to be a sign posted on the wall by the time clock indicating where the most recent survey results were located. She further indicated there was no sign posted to indicate where the survey book was located.</p> <p>3.1-3(b)(1)</p>		<p>as being affected. Meeting was held with residents and social worker informing them of the location of the survey book.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Social worker will notify new admissions and their families the location of the survey book. Location of survey book will be reviewed with cognitive residents after each survey and annually which will be indicated in the social progress note.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The administrator will review the social workers log sheet for notifying residents and family members the location of the survey book which will be reviewed 14 days after new admissions, after each approval of plan of correction submitted to the SBOH and annually thereafter. Q.A. Committee will meet and monitor logs and determine if further monitoring is needed.</p> <p>1. Addendum As stated above: The administrator will review the social workers log sheet for</p>		

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F 0221 SS=D Bldg. 00	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were free of physical restraints related the use of physical restraints without medical symptoms for 2 of 3 residents reviewed for restraints of the 4 residents who met the criteria for physical restraints. (Residents #21 and #18)</p> <p>Findings include:</p> <p>1. On 2/1/16 at 2:13 p.m., Resident #21 was observed sitting in a wheelchair in the Dining Room. A Lap Buddy (padded cushion extending across the residents waist area) device was in place .</p> <p>On 2/2/16 at 11:52 p.m., the resident was</p>	F 0221	<p>notifying residentsand family members the location of the survey book which will be reviewed 14days after new admissions, after each approval of plan of correction submittedto the SBOH and annually thereafter.</p> <p>F221 Based on observation, record review, and interview, thefacility failed to ensure residents were free of physical restraints relatedthe use of physical restraints without medical symptoms for 2 of 3 residentsreviewed for restraints of the 4 residents who met the criteria for physicalrestraints. (Residents #21 and #18)</p> <p>1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Resident #18 & #21 PhysicalTherapist reassessed residents for restraints. An updated restraint assessment was updated and restraints werediscontinued. Resident #18 continues toslide down but he states it is for attention. Resident #21 condition has improved and restraint is not needed at thistime.</p>	03/06/2016			

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	<p>sitting in a wheelchair in the Dining Room. The resident had a Lab Buddy in place.</p> <p>On 2/3/16 at 9:25 a.m., the resident was observed in his room in bed when CNA #1 asked the resident if he could walk. The resident was able to walk from his bed to the wheelchair in his room. The resident walked approximately 4-5 feet without difficulty. The resident sat down in the wheelchair and CNA #1 applied the Lab Buddy to the wheelchair.</p> <p>The record for Resident #21 was reviewed on 2/2/16 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, pressure ulcer, and dehydration.</p> <p>Review of the 11/10/15 Minimum Data Set (MDS) Admission assessment indicated the resident's Brief Interview for Mental Status (BIMS) was a 3. A score of 3 indicated the resident's cognitive patterns were severely impaired. The assessment indicated the resident had no impairment in range of motion and his balance was steady at all times when moving from a seated to standing position, walking, and during surface to surface transfers. The assessment indicated no trunk or limb</p>		<p>All residents restraint assessments were reassessed by Physical Therapist and Restraint Assessments were reviewed by the D.O.N.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Staff will be in-service on proper restraint protocol and proper restraint usage and continue need for reassessment for use of restraint. Charge Nurse will continue to monitor restraint usage on daily monitoring log for each shift and discussed during shift to shift report and restraint will be viewed during tour check.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Charge Nurse is responsible for monitoring proper restraint use. This is monitored 12A, 3A, 5A, 8A, 11A, 2P, 4P, 6P, 9P daily by the charge nurse during nurse rounds and recorded on the log sheet. D.O.N. will monitor round sheets bi-weekly for 1 month then monthly thereafter ongoing. Q.A. Committee will meet and monitor logs and determine if further monitoring is needed and discuss any concerns about restraint use.</p>		

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	<p>physical restraints were used for the resident.</p> <p>An Initial Restraint Evaluation form was completed on 1/15/16. The form indicated an all purpose belt or Lab Buddy was to be used when the resident was up in the chair as the resident continued to get out of the chair without assistance, forgets and ambulates, and attempts to transfer himself.</p> <p>When interviewed on 2/3/16 at 12:47 a.m. LPN #1 indicated the Lab Buddy was in place for the resident as the resident would stand up by himself.</p> <p>When interviewed on 2/3/16 at 2:49 p.m., the Director of Nursing (DoN) indicated the resident had behaviors in December 2015 and had an all purpose belt self release belt applied then. The DoN indicated she first saw the resident with a Lab Buddy in place last Friday. The DoN indicated the staff may have gotten Resident #21 and another resident "mixed up" and placed the Lap Buddy on Resident #21. The DoN indicated Resident #21 was to have a self release belt in place.</p> <p>2. On 2/1/16 at 3:51 p.m., Resident #18 was observed sitting in a wheel chair in the Dining Room with the Lap Buddy</p>		<p>ADDENDUM</p> <p>RESTRAINT PROTOCOL:</p> <p style="text-align: center;">Procedure 575</p> <p>Restraint Devices, Physical</p> <p>BASIC RESPONSIBILITY Licensed Nurse, Nursing Assistant (under the supervision of a Licensed Nurse) and Interdisciplinary Team after assessment from P.T. and order secured by physician.</p> <p>PURPOSE</p> <ul style="list-style-type: none"> · To restrict movement to protect the resident during treatment and diagnostic procedures. · To prevent the resident from injuring himself or others. · Restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff. · To improve the resident's mobility and independent function. · To treat residents' medical symptoms. 				

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	<p>around the front of the wheelchair. The resident was sitting behind the 1/2 circle open back rounded table that was pushed up against the wall. There was no opening for the resident to propel himself out from behind the table. No staff or other residents were at the table with the resident.</p> <p>On 2/2/16 at 7:15 a.m. CNA #1 was observed pushing the resident in his wheelchair into the Dining Room with the Lap Buddy around the front of the wheelchair. The CNA placed the resident behind the 1/2 circle open back rounded table. The CNA then pushed the table up against the wall. There was no opening for the resident to propel himself out from behind the table. The resident remained in the Dining Room until 8:55 a.m. No staff removed the resident from behind the table when the resident was finished with his meal.</p> <p>On 2/3/16 at 8:10 a.m., the resident was observed sitting in a wheelchair behind the 1/2 circle open back table with the Lap Buddy around the front of the wheelchair. The table was pushed up against the wall. There was no opening for the resident to propel himself out from behind the table.</p> <p>On 2/3/16 at 9:00 a.m., the resident was</p>		<p>Assessment Guidelines May include, but are not limited to:</p> <ul style="list-style-type: none"> · Ability to understand instructions and ability to make self understood. · Behavior and mood state. · Functional ability. · Safety. · Change in level of consciousness. · Dehydration and fluid balance. · Potential to injure self or others. · Cooperation with care. · Delirium. · Ability to move in bed. · Ability to transfer safely. · Customary routine. · Bowel and bladder control. <p>PHYSICAL RESTRAINTS are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.</p> <p>EQUIPMENT The appropriate device, to meet the resident's needs, as ordered by a physician.</p> <p>PROCEDURE FOLLOW THE MANUFACTURER'S INSTRUCTIONS FOR ALL RESTRAINT DEVICES. 1. Assess resident's need for restraint device use.</p>	

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	<p>observed in a wheelchair in the hallway leading into the Dining Room. The DoN and CNA #1 asked the resident to stand. The resident was able to stand up from the wheelchair and hold on to the hand rail on the wall. The resident was able to ambulate hunched forward with his knees bent and he walked slowly toward the Dining Room.</p> <p>On 2/4/16 at 8:10 a.m., Resident #18 was observed in a wheelchair and propelling from the hallway into the Dining Room without difficulty.</p> <p>On 2/4/16 at 12:38 p.m., the resident was observed sitting on a chair at the 1/2 circle open back table.. The table was pushed up against the wall. There was no opening for the resident to propel himself out from behind the table.</p> <p>The record for Resident #18 was reviewed on 2/2/16 at 2:35 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, dementia with agitated features, diabetes mellitus, and anxiety.</p> <p>Review of the 1/13/16 Minimum Data Set (MDS) quarterly assessment indicated a BIMS (Brief Interview for Mental Status) was not completed. The resident was unable to complete the</p>		<p>2. Obtain informed consent for restraint device use.</p> <p>3. Obtain physician's order for restraint device.</p> <p>4. Develop or review resident care plan for type of restraint device, reason for use, alternate methods to be used and method of application. List medical symptoms to be treated and methods to reduce and eliminate the restraint device.</p> <p>5. Gather equipment; bring to bedside.</p> <p>6. Identify resident and explain procedure in a calm manner.</p> <p>7. Screen the resident for privacy.</p> <p>DOCUMENTATION GUIDELINES Documentation may include:</p> <ul style="list-style-type: none"> · Date, time, as appropriate. · Method(s) utilized before restraint device. · Fall risk assessment. · Assessment for restraint device use. · Consent for restraint device use. · Prior methods used to control symptoms, and whether or not these methods were effective. · Date, time and medical symptoms that led to the use of the restraint device. · Cause of the resident's medical symptoms. · Degree of pain and effectiveness of pain management. · Type of restraint device used. · Monitoring resident. 		

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	<p>interview. The assessment indicated the resident had not fallen and no trunk or limb restraints were in place. No physical restraint assessment was provided.</p> <p>The 2/2016 Physician Order Statement was reviewed. An order was written on 12/9/15 for a Lab Buddy to be applied when the resident was up in the wheelchair.</p> <p>When interviewed on 2/3/16 at 2:50 p.m., the DoN indicated there should have been a restraint assessment completed. The DoN indicated the resident should not have been placed behind the table with no means to remove himself from the area. The DoN indicated the Lab Buddy was initiated as the resident would slide from his chair when sitting at the table.</p> <p>3.1-26(o)</p>		<ul style="list-style-type: none"> ·Frequency and length of time the restraint device is released. ·Condition of the area restrained. ·Condition of the resident while restrained. ·Effectiveness of the restraint. ·Repositioning, exercise and toileting of the resident. ·Other measures used to control the resident's medical symptoms. ·Measures to prevent complications. ·Signature and title. <p>CARE PLAN DOCUMENTATION GUIDELINES Problem:</p> <ul style="list-style-type: none"> ·Identify medical symptoms to be treated. ·Identify the appropriate problem under which to list restraint use as an approach. ·Consider listing possible risks and complications. <p>Goal:</p> <ul style="list-style-type: none"> ·List MEASURABLE goal(s) to be accomplished. Goal should lead to removal of restraints or use of less restrictive measures. ·List target date. <p>Approaches:</p> <ul style="list-style-type: none"> ·List responsible discipline for each approach. ·List instructions unique to this resident. ·List necessary monitoring and observation of the condition that necessitates restraint use. ·List observation for effectiveness of treatment. 		

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			<ul style="list-style-type: none"> ·Listalternate methods used. ·Listplan to reduce and eliminate restraint use. ·Listrestraint removal, exercise, positioning and check of circulation, ifappropriate. ·Listtype of restraint to be used and method of application. Listobservation for risks and complications <p>Effectivenessof restraint use is monitored to see if it helps the resident to maintain safebody alignment positioning in chair or geri-chair. Example: A resident with Huntington's Chorea whocannot control lower extremities and unable to sit in a chair due to theconstant leg movement can benefit from a restraint being placed around histhigs while in a chair. This lessensthe leg movement and allows the resident to sit upright in a chair. The resident has to be monitored andrepositioned to maintain the proper body alignment and restraint has to bereleased for ambulation, toileting and upon request under staff supervision. If therestraint recommended by the physical therapist becomes ineffective then newmeasures are tried until the optimal positioning device is secured for theresident to meet their needs. Resident#18 does not have a restraint and he still positions himself on the floor wherehe states he is more comfortable.</p>	

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F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his</p>		<p>This is still a problem when he goes to dialysis because family is with the resident. Resident is able to walk with a walker and understands what he is doing so staff tries to encourage him to lay in his bed instead of the floor.</p>	

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	<p>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 verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to obtain criminal history checks for newly hired employees prior to employment for 3 of 5 employees hired in the last 120 days.</p> <p>Finding includes:</p> <p>1. The employee files were reviewed on 2/4/16 at 2:30 p.m.</p> <p>A. Dietary Aide #1 was hired on 11/12/15 and there was no criminal history background check completed for the employee.</p> <p>B. CNA #2 was hired on 1/15/16. The employee's background information had been sent to a reporting State Agency on 1/16/16.</p> <p>Interview with the Social Service Designee on 2/4/16 at 3:15 p.m., indicated she had not received the results of the background check.</p> <p>C. CNA #3 was hired on 11/21/15. The employee was born in 1996. The</p>	F 0225	<p>F 225 Based on record review and interview, the facility failed to obtain criminal history checks for newly hired employees prior to employment for 3 of 5 employees hired in the last 120 days.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>The facility has always mailed the criminal background check to the Indiana State Policy for all of our employees.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All potential employees who have completed their physical and mantoux requirements will have a criminal background check performed via Indiana State Police web site. An account is currently being set up with the Indiana State Police and increase in price has been indicated. Criminal background checks via the mail was \$7.00 now to receive information it will be \$16.25. The result of the</p>	03/06/2016

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	<p>employee had gone to a local county government center and obtained a background check, however, the results were only for the county in which she lived in and not for the entire state.</p> <p>Interview with the Social Service Designee 2/4/16 at 3:15 p.m., indicated she was informed CNA #2 and Dietary Aide #1 needed fingerprints to complete their criminal history background checks. She further indicated both employees were over the age of 18.</p> <p>Interview with the Director of Nursing on 2/4/16 at 3:30 p.m., indicated she was unaware the criminal history checks had not been completed.</p> <p>3.1-28(b)(1)</p>		<p>background check will immediately be given to the Administrator and D.O.N. prior to scheduling.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-Service held on Background Check Procedure with office personnel. A log book will be set up for all current employees and employees hired in the last 120 days and Physical, PPD 1st step and 2nd step/ or chest x-ray, Criminal background check, license and/or certifications dementia training and job orientation, residents rights and abuse policy.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Office manager will be responsible for keeping book updated as new employees are hired. Administrator and D.O.N. will review all personnel records before a new hire is scheduled and semi-annually. Q.A. Committee will review new hire binder which will include but not limited to physical, mantoux 1st and 2nd step, criminal background checks, job orientation and dementia, resident rights and</p>	

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			<p>abuse training quarterly. Q.A. will determine if further monitoring is needed.</p> <p>ADDENDUM:</p> <p>On 3/16/16 IN.gov the State of Indiana web portal was approved and now Mrs. Dumas R.N. D.O.N. is responsible for all criminal background checks being performed before new employee is hired.</p> <p>On-line criminal history checks were performed on Dietary Aide #1 and C.N.A. #2 however by C.N.A. #3 being under the age of 18 no criminal history check could be done however finger printing was performed. Criminal background checks through the State of Indiana State Police is unavailable for anyone under 18, however when</p>		

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the Abuse Prevention Policy related to obtaining criminal history checks for newly hired employees prior to employment for 3 of 5 employees hired in the last 120 days.</p> <p>Finding includes:</p> <p>1. The employee files were reviewed on 2/4/16 at 2:30 p.m.</p> <p>A. Dietary Aide #1 was hired on</p>	F 0226	<p>the employee turns 18 a criminalbackground check will be performed through the Indiana State Police.</p> <p>Q.A.will review this issue in one quarter and no further monitoring is necessaryfor this issue.</p> <p>F 226 Based on record review and interview, thefacility failed to follow the Abuse Prevention Policy related to obtainingcriminal history checks for newly hired employees prior to employment for 3 of5 employees hired in the last 120 days.</p> <p>1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>The facility has alwaysmailed the criminal background check to the Indiana State Policy for all of ouremployees.</p> <p>1.Describe how the facility</p>	03/06/2016	

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	<p>11/12/15 and there was no criminal history background check completed for the employee.</p> <p>B. CNA #2 was hired on 1/15/16. The employee's background information had been sent to a reporting State Agency on 1/16/16.</p> <p>Interview with the Social Service Designee on 2/4/16 at 3:15 p.m., indicated she had not received the results of the background check.</p> <p>C. CNA #3 was hired on 11/21/15. The employee was born in 1996. The employee had gone to a local county government center and obtained a background check, however, the results were only for the county in which she lived in and not for the entire state.</p> <p>Interview with the Social Service Designee 2/4/16 at 3:15 p.m., indicated she was informed CNA #2 and Dietary Aide #1 needed fingerprints to complete their criminal history background checks. She further indicated both employees were over the age of 18.</p> <p>Interview with the Director of Nursing on 2/4/16 at 3:30 p.m., indicated she was unaware the criminal history checks had not been completed.</p>		<p>reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All potential employees who have completed their physical and mantoux requirements will have a criminal background check performed via The Indiana State Police web site. The result of the background check will immediately be given to the Administrator and D.O.N. prior to scheduling.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-Service held on Background Check Procedure with office personnel. A log book will be set up for all current employees and employees hired in the last 120 days and Physical, PPD 1st step and 2nd step, Criminal background check, license and/or certifications dementia training and job orientation.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Office manager will be responsible for keeping book updated as new</p>	

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	<p>The current undated Prevention and Reporting of Suspected Resident and Abuse and Neglect Policy provided by the Director of Nursing on 2/5/16 at 8:00 a.m., indicated "Screen all potential employees for a history of abuse, neglect or mistreating resident's during the hiring process. Screening will consist of but not limited to, criminal background checks on all non professional personnel 18 years of age and older."</p> <p>3.1-28(a)</p>		<p>employees are hired. Administrator and D.O.N.will review all personnel records before a new hire is scheduled andsemi-annually. Q.A. Committee will review new hire binderwhich will include but not limited to physical, mantoux 1st and 2ndstep, criminal background checks, job orientation and dementia, resident rightsand abuse training quarterly. Q.A. willdetermine if further monitoring is needed.</p> <p>ADDENDUM: On 3/16/16 IN.gov the State of Indiana web portal wasapproved and now Mrs. DumasR.N. D.O.N. is responsible for all criminal background checksbeing performed before new employee is hired. On-linecriminal history checks were performed on Dietary Aide#1 and C.N.A. #2 howeverby C.N.A. #3 being under the age of 18 no criminal history check could be donehowever finger</p>	

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F 0241 SS=D 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. Based on observation, record review and interview, the facility failed to ensure staff signs with personal information about residents were not posted on the wall above the bed for 1 of 1 residents	F 0241	printing was performed. Criminal background checks through the State of Indiana State Police isunavailable for anyone under 18, however when the employee turns 18 a criminalbackground check will be performed through the Indiana State Police. Q.A.will review this issue in one quarter and no further monitoring is necessaryfor this issue. F 241 Based on observation, record review and interview, thefacility failed to ensure staff signs with personal information about residentswere not posted on the wall above the bed for 1 of 1 resident reviewed fordignity.	03/06/2016

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	<p>reviewed for dignity. (Resident #20)</p> <p>Finding includes:</p> <p>On 2/1, 2/2, 2/3, and 2/4/16 during the day tour of duty (8:00 a.m. until 4:00 p.m.) there was a sign posted above Resident #20's bed. The sign indicated "Please keep the head of the bed elevated (arrow up) at all times."</p> <p>Interview with the Director of Nursing on 2/3/16 at 2:45 p.m., indicated staff had placed the sign above the resident's bed due to the resident having a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube placed directly into the resident's stomach through the abdomen that provides nutrition) and the fact he was NPO (nothing by mouth).</p> <p>3.1-3(t)</p>		<p>(Resident #20)</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. All residents rooms were toured and sign was immediately removed.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Nother signs noted in resident rooms.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Staff was in-serviced and review on HIPPA regulations was done.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Charge Nurse is responsible for monitoring for any signs posted in resident rooms that would infringe on resident's privacy and indicate on logsheet. This is monitored daily during tour check. D.O.N. will monitor for signs being posted during daily rounds 5 days a week for 1 week then monitor logs monthly for 1 month then quarterly. Q.A. Committee will</p>		

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F 0247 SS=D Bldg. 00	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a resident was given notice prior to a room change for 1 of 1 residents reviewed for Admission, Transfer, and Discharge of the 1 resident who met the criteria for Admission, Transfer, Discharge. (Resident #9)</p> <p>Finding includes:</p> <p>Interview with Resident #9 on 2/1/16 at 11:03 a.m., indicated he had not been given notice prior to moving to a new room.</p> <p>The record for Resident #9 was reviewed on 2/4/16 at 1:10 p.m.</p>	F 0247	<p>meetand monitor logs and determine if further monitoring isneeded and discuss any concerns about restraint privacy & HIPPA. ADDENDUM Q.A.Committee will meet at quarterly meeting and monitor logs and perform a tour ofresident care areas then tour for this issue will be monitored semi-annually.</p> <p>F 247 Based on record review and interview, the facilityfailed to ensure a resident was given notice prior to a room change for 1 of 1residents reviewed for Admission, Transfer, and Discharge of the 1 resident whomet the criteria for Admission, Transfer, Discharge. (Resident #9) 1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Social Worker interviewedResident #9 to ensure the resident was pleased with his room change and did notwant to transfer to another room. 1.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and</p>	03/06/2016	

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	<p>An intrafacility transfer form dated 1/15/15 indicated the resident was moved from 113-2 to room 118-1 due to maintenance. The resident had signed the transfer notice.</p> <p>An intrafacility transfer form dated 2/3/15 indicated the resident was moved to room 103-2 from 118 due to maintenance. The resident had signed the transfer notice.</p> <p>There was no documentation in Nursing Progress notes or Social Service notes for the months of 3/2015-12/2015, 1/2016 and 2/2016, indicating the resident was given notice before being moved to his new room 115-2</p> <p>Interview with the Social Service Designee on 2/4/16 at 1:30 p.m., indicated she cannot remember when the resident was moved to room 115-2. She further indicated an intrafacility transfer form should have been completed prior to the move.</p> <p>3.1-3(v)(2)</p>		<p>state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected. The Social Worker will inform all residents of potential room changes and review anintra-facility transfer form with them. The Social Worker will document room transfer and how resident hasresponded to the room change.</p> <p>1.Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Administrator will reviewall room changes with Social Worker. Thesocial worker will provide administrator with a copy of the intra-facilitytransfer form and progress note documentation.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Administrator will reviewintra-facility transfers as they occur. Q.A. Committee will meet and intra-facilitytransfers and resident's response to relocation and determine if furthermonitoring is needed.</p> <p>ADDENDUM No other residents were effected allresidents admitted in the facility still have their</p>		

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F 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for</p>		<p>same room number. We are a small facility so this is easy to monitor.</p> <p>The administrator approves all intra-facility transfers and will review the intra-facility documentation performed by the social service department. Q.A. will monitor this at quarterly meeting and practice will be reviewed only when intra-facility transfers occur.</p>		

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	<p>each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement. Based on observation, record review, and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's status related to dental status and range of motion for 2 of 12 residents reviewed. (Residents #21 & #17)</p> <p>Findings include:</p> <p>1. On 2/1/16 at 11:37 a.m., Resident #21 was observed in his room. The resident did not have any natural teeth or dentures in place.</p> <p>The record for the resident was reviewed on 2/2/16 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, pressure ulcer, and dehydration.</p> <p>The 11/10/15 Minimum Data Set (MDS) Admission assessment was reviewed. The Oral/Dental section was not coded correctly as the resident had no natural teeth. The Oral/Dental section for "no natural teeth or tooth fragments" and "edentulous" were not checked as positive. 2. On 2/3/16 at 9:52 a.m., Resident #17 was observed sitting in her</p>	F 0278	<p>F278</p> <p>Based on observation, record review, and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's status related to dental status and range of motion for 2 of 12 residents reviewed. (Residents #21 & #17)</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The current MDS for Resident 21 have been checked and is accurate indicating noteeth. Resident # 17 current MDS has been checked and is accurate indicating Range of Motion for lower extremitiesimpairment coded a 1 and upper extremities coded a 1</p> <p>2. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action will be taken. Prior MDS Nurse was terminated and new MDS Coordinator is being trained. Potentially other errors could be found to affect the accuracy of the MDS for all residents. All residents MDS due for the month ofFebruary have been audited and checked for accuracy. MDS due for the</p>	03/06/2016

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	<p>wheelchair in her room listening to music.</p> <p>The Minimum Data Set (MDS) Admission assessment dated 9/3/15 was reviewed on 2/3/16 at 9:52 a.m. Locomotion on and off unit was coded as supervision only. Range of motion for upper extremities was coded as a (1) which indicated impairment on one side of the residents body. The lower extremities was coded as a (0) which indicated no impairment. The MDS Quarterly assessment dated 11/25/15 was coded a (1) for Range of motion for the residents lower extremities which indicated impairment. The diagnosis included , but were not limited to, acute cerebral vascular accident, mentally challenged, seizure disorder, and left side hemiparesis.</p> <p>The Physician orders were reviewed for the resident. The Neurologist ordered ambulatory physical therapy on 9/3/15</p> <p>Interview on 2/05/16 at 8:58 a.m. with CNA #5 indicated the resident propels herself in her wheelchair by using her feet now.</p> <p>Interview on 2/4/16 at 2:42 p.m. with the Director of Nursing (DoN) indicated, the Admission MDS Range of Motion was</p>		<p>month of March will be audited as the MDS becomes due by MDS Coordinator. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. MDS In –Service will be presented with focus on tools used to ensure accuracy of assessments with emphasis on dental assessment and ROM. The D.O.N. is responsible for the MDS process and training staff to the Point ClickCare Computer System for the MDS process. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. will review 4 MDS weekly for accuracy related to dental assessment and ROM. Director of Nursing will audit MDS for accuracy prior to transmission. The nursing staff will participate in ongoing training. Q.A. will evaluate the practice to ensure this corrects prior deficiency. QA will review the progress of staff knowledge of MDS assessment and Point Click Care computerized program and make recommendation as needed.</p>				

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F 0279 SS=D Bldg. 00	<p>coding incorrectly. She indicated that the Range of Motion for lower extremities should have been coded a (1) for impairment. The resident was admitted and could not walk and now she can.</p> <p>3.1-31(d)</p> <p>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.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to develop a</p>	F 0279	F 279 Based on observation, record review, and interview, the facility failed to develop a	03/06/2016	

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	<p>comprehensive care plan related to positioning, restraints, and pressure ulcers for 1 of 2 residents reviewed for positioning and for 1 of 3 residents reviewed for restraints and pressure ulcers. (Residents #10 and #21)</p> <p>Findings include:</p> <p>1. On 2/1/16 at 10:36 and 10:47 a.m., Resident #10 was observed in his wheelchair at a table in the Dining Room. The resident was observed leaning toward his left side and his left arm hanging down with his armpit on the arm rest of the wheelchair. There were no cushions or a pillow observed in the wheelchair.</p> <p>On 2/2/16 at 8:10 a.m., 11:08 a.m., and 11:34 a.m., the resident was observed sitting in the wheelchair leaning to the left side. The resident's entire body was leaning to the left side and his armpit was laying on the arm rest of the wheelchair. There was no cushion, padding or pillow observed in the wheelchair.</p> <p>On 2/2/16 at 3:00 p.m. the resident was observed in his room with the lights off and the door closed. The resident was leaning to the left side in his wheelchair. There was no staff in the room. There was no pillow, cushion or positioning</p>		<p>comprehensive care plan related to positioning, restraints, and pressure ulcers for 1 of 2 residents reviewed for positioning and for 1 of 3 residents reviewed for restraints and pressure ulcers. (Residents #10 and #21)</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #10 Care Plan was updated to include positioning of the resident leaning to the left side. Resident #21 Care Plan was updated to include decubitus ulcer care and restraint.</p> <p>1. HOW WERE RESIDENTS REVIEWED THAT WOULD BE AFFECTED? All other residents with positioning problems care plan was reviewed and modified as needed. No other residents have any pressure areas in the facility, however any resident who is admitted with problems with their skin integrity will be addressed in the care plan.</p> <p>2. MEASURES TAKEN TO CORRECT DEFICIENT PRACTICE. All nursing staff was in-serviced on proper positioning of residents and skin protocol to prevent and heal problems in skin integrity. Charge Nurse will continue to monitor all residents that require the use of a wheelchair and/or geri-chair for proper</p>	

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	<p>device observed in the wheelchair.</p> <p>On 2/3/16 at 8:09 a.m., the resident was observed sitting in a wheelchair in the hallway. At that time, he was leaning to the left side and his armpit was resting on the arm rest of the chair. There was no pillow, cushion or positioning device observed in the wheelchair.</p> <p>On 2/3/16 at 1:00 p.m., the resident was observed sitting in his wheelchair in his room by himself. The resident was observed leaning to the left side in the wheelchair, with his left arm hanging over the side. There was no pillow, cushion or positioning device observed in the wheelchair.</p> <p>The record for Resident #10 was reviewed on 2/2/16 at 11:11 a.m. The resident's diagnoses included, but were not limited to, bilateral lower extremity swelling, dementia, failure to thrive, behavioral issues, risk for falls, agitation, altered mental status, epilepsy, and left side weakness.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 11/27/15 indicated the resident was not alert and oriented, and had a Brief Interview for Mental Status (BIMS) of 4 which means the resident was severely impaired for decision</p>		<p>positioning and indicate it on the monitoring log foreach shift. All residents requiring arestraint use daily and indicated in chartingand monitoring log for each shift., All residentscare plans were reviewed by licensed nurse according to their assignment. MDS Coordinatorwill review care plans to ensure it meets the needs of each resident. DON will reviewcare plan problems weekly to ensure updates have been completed.</p> <p>3.Criteria used to determine when the monitoring may be stopped includes thefollowing: The D.O.N. willreview 4 residents care plans each week to ensure all problems have beenaddressed. D.O.N. willkeep a printed listing of all residents and their care problems and review it weekly with MDS Coordinator. Monitoring willbe ongoing by nursing department.</p> <p>Q.A. willevaluate the practice to ensure this corrects prior deficiency. The effectiveness will be determined by allresidents exhibiting positioning problems, pressure areas, restraint devicesand peg tubes.</p> <p>ADDENDUM: ALLASPECTS OF CARE FOR EACH RESIDENTS CARE PLAN ARE REVIEWED. INREVIEWING THE CARE PLAN THE FOLLOWING IS DONE: 1.EACH DIAGNOSIS ISADDRESSSED ON</p>		

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	<p>making. The resident needed limited assist with one person physical assist with transfers, locomotion on and off the unit. The resident had no range of motion limitations to upper and lower extremities. The resident was not steady and required assist with moving from a seated position.</p> <p>The current and updated 11/2015 care plan was reviewed. There was no care plan for the resident's positioning problem and leaning to the left side.</p> <p>Interview with the Director of Nursing on 2/3/16 at 1:39 p.m., indicated there was no current plan of care with Nursing interventions for the resident's positioning problem.</p> <p>2. On 2/2/16 at 11:52 a.m., Resident #21 was observed sitting in a wheel chair in the Dining Room. The resident had a Lap Buddy restraint in place.</p> <p>The record for the resident was reviewed on 2/2/16 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, pressure ulcer, and dehydration.</p> <p>Review of the current Physician orders indicated there were orders for a treatment to a pressure ulcer on</p>		<p>THE CARE PLAN RELATED TO MEDICATION.</p> <p>2.THE NEEDS OF THERESIDENT IN WHICH THE RESIDENT IS ABLE TO PERFORM A TASK TO IMPROVE THE PROBLEM WILL BE INDICATED AS A PROBLEM AND A GOAL WILL BE RESIDENT CENTERED.</p> <p>3.INTERVENTIONS WILL INDICATE WHAT THE RESIDENT OR STAFF MEMBER MUST DO IN ORDER FOR THE RESIDENT TO HAVE AN OPTIMAL OUTCOME FOR THE PROBLEM NOTATED.</p> <p>4.ALL DISCIPLINARY STAFF IS TRAINED ONGOING TO THE CARE PLAN PROCESS AND PROBLEMS AND CHANGES IN INTERVENTIONS ARE UPDATED ONGOING AS THEY OCCUR.</p> <p>Q.A.WILL MONITOR LOGS FOR CARE PLAN CHANGES TRACKING LOG QUARTERLY THEN SEMI-ANNUALLY. THE CRITERIA THAT WILL BE USED IS TO MONITOR FOR CHANGE IN CONDITION, NEW MEDICATIONS AND NEW DIAGNOSIS UPDATES ON CARE PLAN.</p>				

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F 0280 SS=D Bldg. 00	<p>the resident's coccyx. The resident's current Care Plans were reviewed. No Care Plans were noted related to pressure ulcers and physical restraints.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 11/10/15, indicated that pressure ulcer triggered on CAAS to be care planned.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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</p>			

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	<p>after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure residents were invited to care plan meetings for 1 of 1 residents reviewed for care planning decision of the 1 resident who met the criteria for care planning decision. (Resident #13)</p> <p>Finding includes:</p> <p>Interview with Resident #13 on 2/1/16 at 10:25 a.m., indicated he had never been involved in a care plan meeting.</p> <p>The record for Resident #13 was reviewed on 2/2/16 at 1:17 p.m.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 12/30/15 indicated the resident had some moderate impairment for cognitive status with a Brief Interview for Mental Status (BIMS) score of 10.</p> <p>Social Service Progress notes indicated the last documented Social Service Note was dated 7/15/2015. There was no documentation the resident and/or an interested family member was invited to a care plan meeting.</p> <p>A care plan invitation notice dated 5/14/15 was noted in the resident's chart.</p>	F 0280	<p>F Tag 280 Comprehensive Care Plan Based on record review and interview, the facility failed to ensure residents were invited to care plan meetings for 1 of 1 resident reviewed for care planning decision of the 1 resident who met the criteria for care planning decision. (Resident #13)</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #13 care plan was reviewed with him by the Social Worker and responses are documented in the social service progress notes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken No other residents were affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Care plans will assign by the D.O.N. to the charge nurses then reviewed by the D.O.N. Social Worker will be giving a schedule and will advise family members of care conference and document information in progress note indicating if they will attend or if they prefer a telephone conference. Social Service will use log sheet to include Residents Name, Date of Care Conference and Time, Responsible Party of whom</p>	03/06/2016

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	<p>Interview with the Social Service Designee on 2/2/15 at 1:40 p.m., indicated care conferences were held at least quarterly or when there was a change in the resident's condition. She further indicated there was no documentation the resident was invited to his last care plan conference.</p> <p>3.1-35(d)(2)</p>		<p>Social Worker or Social Service Designee has spoken to and Yes or No if they will be attending the care conference. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Administrator will monitor care conference log weekly times one month then quarterly then refer to Q.A. Committee Care team will review care plans according to the MDS schedule. D.O.N. will review care conference log sheets weekly and submit to Administrator for review. D.O.N. weekly audits will be performed according to MDS schedule. Q.A. Committee will review care conference logs and determine need for ongoing monitoring to correct site deficient practice to prevent reoccurrence.</p> <p>ADDENDUM AT THE BI-WEEKLY CARE CONFERENCE TEAM MEETING WITH THE INTRADISCIPLINARY TEAM SOCIAL SERVICE DEPARTMENT DISCUSSES THE MEETING WITH THE FAMILY/RESIDENT AND SCHEDULES THE NEXT GROUP OF RESIDENTS INVITED TO CARE CONFERENCE. THE NOTATION IS PLACED IN THE PROGRES NOTE AND ON THE SOCIAL WORKER CONSULTANT REPORT FOR Q.A. COMMITTEE AND ADMINISTRATOR REVIEW.</p> <p>Q.A. WILL MONITOR</p>		

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to follow Physician Orders related to the completion of labs for 1 of 5 residents reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Resident #10)</p> <p>Finding includes:</p> <p>The record for Resident #10 was reviewed on 2/2/16 at 11:11 a.m. The resident's diagnoses included, was not limited to, bilateral lower extremity swelling, congestive heart failure, dementia, vitamin b deficiency, pancreatitis, failure to thrive, malnutrition, high blood pressure, and epilepsy.</p> <p>Physician Orders on the current 2/2016 recap indicated the resident was to have a</p>	F 0282	<p>THISQUARTERLY THEN SEMI-ANNUALLY BUT IF NEW PERSONELL FOR THE SOCIAL SERVICEDEPARTMENT OCCURS MORE MONITORING WILL BE DONE TO ENSURE SAME PRACTICE ISFOLLOWED</p> <p>F282 Based on record review andinterview the facility failed to follow Physician Orders related to thecompletion of labs for 1 of 5 residents reviewed for unnecessary medications ofthe 5 residents who met the criteria for unnecessary medications. (Resident #10) 1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Resident #10 Nursenotified the physician and labs were rescheduled and drawn from resident whowas cooperative 1.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected. Nooter residents affected. 1.Describe the steps or systemic changes the facility has</p>	03/06/2016	

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	<p>wellness and liver profile lab draw every 6 months in June and December</p> <p>The last wellness and liver profile was completed on 6/10/15. The labs had not been completed in December 2015.</p> <p>The laboratory had been notified and provided information which indicated the resident had refused the lab draw on 12/23/15. The resident was supposed to have a Chemistry profile, lipid profile, liver profile, T 4 free (thyroid test), TSH (thyroid test), and CBC (Complete Blood Count).</p> <p>Interview with LPN #1 on 2/3/16 at 1:36 p.m., indicated the resident had refused the wellness and liver profile lab draw in December 2015. She further indicated the labs had not been completed as ordered by the Physician.</p> <p>3.1-35(g)(2)</p>		<p>made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Licensed Nursing Staff was in-serviced on proper procedures for securing labs for residents who have refused. 1. Notify the physician, 2. Notify the family, 3. Reschedule lab draw. 4. If resident still refuses the physician will be consulted and indicate new orders. All lab refusals will be documented in the nurses notes and shift to shift report during 24 hour report. A copy of all lab refusals requisitions will be reported to D.O.N. D.O.N. will monitor lab refusals to ensure labs are rescheduled and discuss problems during Q.A.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Midnight Charge Nurse is responsible for all monitoring of lab orders and providing a copy of a lab refusal to the D.O.N. Midnight Charge Nurse will notify physician, receive new orders, notify family member of the lab refusal. Midnight Charge Nurse will be responsible for rescheduling the ordered lab or discontinuation of the lab per physician's orders. D.O.N. will monitor lab draws and audit sheets monthly to ensure labs are drawn</p>		

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F 0309 SS=G Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were attained to maintain a resident's psychosocial well being, socialization, and self ambulation related to the continued use of a Lab Buddy trunk restraint (padded cushion extending across the residents waist area). (Resident #18) The facility failed to ensure ongoing assessment of the resident's</p>	F 0309	<p>as prescribed by physician. D.O.N. will monitor lab refusals asthey occur ongoing. Q.A. Committee will meet and monitor labaudits and refusal lab logs and determine if further monitoring is needed.</p> <p>ADDENDUM ALL OF OUR RESIDENTS EXCEPT FOR 3 WERE REVIEWED DURINGTHE SURVEY AND THOSE 3 RESIDENTS ARE COMPLIANT WITH LAB DRAWS. LAB AUDITS ARE PERFORMED BY METHODISTHOSPITAL AND NO ONE ELSE REFUSED LABS.</p> <p>F309A Based on observation, record review and interview, thefacility failed to ensure the necessary treatment and services were attained tomaintain a resident's psychosocial well being, socialization, and selfambulation related to the continued use of a Lab Buddy trunk restraint (paddedcushion extending across the residents waist area). (Resident #18) The facilityfailed to ensure ongoing assessment of the resident's</p>	03/06/2016

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	<p>hemo-dialysis graft were completed every shift and before and after each dialysis treatment for 1 of 1 residents reviewed for Dialysis. (Resident #18)</p> <p>The facility also failed to provide to provide adequate chair positioning devices for 2 of 3 residents who were dependent on staff for positioning. (Residents #10 and #20)</p> <p>Finding includes:</p> <p>1. On 2/1/16 at 3:51 p.m., Resident #18 was observed sitting in a wheel chair in the Dining Room with the Lap Buddy around the front of the wheelchair. The resident was sitting behind the 1/2 circle open back rounded table that was pushed up against the wall. There was no opening for the resident to propel himself out from behind the table. No staff or other residents were at the table with the resident.</p> <p>On 2/2/16 at 7:15 a.m. CNA #1 was observed pushing the resident in his wheelchair into the Dining Room with the Lap Buddy around the front of the wheelchair. The CNA placed the resident behind the 1/2 circle open back rounded table. The CNA then pushed the table up against the wall. There was no opening for the resident to propel himself out from behind the table. The resident</p>		<p>hemo-dialysis graft werecompleted every shift and before and after each dialysis treatment for 1 of 1residents reviewed for Dialysis. (Resident #18)</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency. Old dialysis communication forms were immediately removed fromnurses station. D.ON. developed a policy and procedure for AVfistula care for dialysis residents in 12/ 2/2012. It has been a part of the Licensed NurseOrientation Binder reviewed and given to each licensed nurse. A copy of the proper form and policy isreviewed with each licensed nurse. Locks were put on all circuit boxes throughoutthe facility. Resident #18 had neverdisplayed this behavior prior to survey. Staff instructed not to allow anyone into thedining room unless staff is present. Resident's will wait in their rooms or by the nurses station untildining room is opened so that proper supervision is available. Resident # 18 had not exhibited trying to open the door prior to survey. Resident #18 was removed from inner circle of table and staff and resident instructed not to sit behind table. Resident #18 displays attention seeking behavior even though he is aware of what is right and wrong. Resident #18 behaviors is receiving care under the</p>	

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	<p>remained in the Dining Room until 8:55 a.m. No staff removed the resident from behind the table when the resident was finished with his meal.</p> <p>On 2/3/16 at 8:10 a.m., the resident was observed sitting in a wheelchair behind the 1/2 circle open back table with the Lap Buddy around the front of the wheelchair. The table was pushed up against the wall. There was no opening for the resident to propel himself out from behind the table.</p> <p>On 2/3/16 at 9:00 a.m., the resident was observed in a wheelchair in the hallway leading into the Dining Room. The DoN and CNA #1 asked the resident to stand. The resident was able to stand up from the wheelchair and hold on to the hand rail on the wall. The resident was able to ambulate hunched forward with his knees bent and he walked slowly toward the Dining Room.</p> <p>On 2/4/16 at 8:10 a.m., Resident #18 was observed in a wheelchair and propelling from the hallway into the Dining Room without difficulty.</p> <p>On 2/4/16 at 9:24 a.m., Resident #18 was observed in a wheelchair in the Dining room. There were two small dressing on the resident's right upper arm.</p>		<p>psychiatrist and family physician but currently his behavior at dialysis is uncontrollable and they have threatened to stop dialysis on this resident. The other dialysis unit in the area has refused to service this resident for dialysis. Interventions of increased medications are currently being prescribed for this resident. Father is present for all dialysis visits and conferences held on how to manage his son's attention seeking behavior.</p> <p>2. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. All charge nurses were disciplined for using the wrong forms. The practice of the facility is to in-service staff when new forms or protocols are implemented. If you request a copy of a form and it does not look like the form you have been using do not use it. In-service on hemodialysis assessment policy and listen to the bruit q shift, feel the thrill q shift and look at AV fistula site for complications was added to the M.A.R. and care plan for Resident #18. Proper hemodialysis form was reviewed with each licensed nurse by D.O.N. No other residents affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should</p>		

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	<p>On 2/4/16 at 12:38 p.m., the resident was observed sitting on a chair at the 1/2 circle open back table.. The table was pushed up against the wall. There was no opening for the resident to propel himself out from behind the table.</p> <p>The record for Resident #18 was reviewed on 2/2/16 at 2:35 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, dementia with agitated features, diabetes mellitus, and anxiety.</p> <p>Review of the 1/13/16 Minimum Data Set (MDS) quarterly assessment indicated a BIMS (Brief Interview for Mental Status) was not completed. The resident was unable to complete the interview. The assessment indicated the resident had not fallen and no trunk or limb restraints were in place. No physical restraint assessment was provided. The assessment indicated the resident required extensive assistance of staff for dressing, personal hygiene, and bed mobility.</p> <p>The 2/2016 Physician Order Statement was reviewed. An order was written for the resident to receive Hemo-Dialysis on Mondays, Wednesdays, and Fridays. An order was written on 12/9/15 for the</p>		<p>include any systemchanges you made.</p> <p>Staff was in-serviced onproper hemodialysis communication form and proper care for dialysisresident. Documentation of resident'sassessment prior to transfer to dialysis and return assessment in the nursesnotes. MAR assessment ofhemodialysis shunt Q shift. Licensed Nurse willupdate the Care Plan as needs change for dialysis residents. Resident #18 behaviorwill continue to be monitored and documented in nurses notes and discussed withfamily, physician and psychiatrist. Dialysis center will be encouraged to record behavior problems duringhemodialysis on hemodialysis communication sheet so that it can be discussedwith physicians and family. All nursing staffin-serviced on not to let any resident behind the semi-circles of the feedingtables.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Charge Nurse is responsible for ensuring monthly MAR recap has Listen to the bruit q shift. Feel the thrill q shift. Look at AV fistula site for complicationsq shift. Charge Nurse is responsible for completing dialysiscommunication sheet on</p>	

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	<p>resident to have a Lap Buddy when up in the wheelchair.</p> <p>The 1/2016 Nursing Notes were reviewed. The following entries were noted: 1/9/16 at 6:56 a.m.- The resident slid to the floor out of the wheelchair and began telling staff they should get him up. 1/13/16 at 4:11 a.m. - The resident was observed ambulating down the hall with a walker. The resident stated he was waiting for a ride. 1/14/16 at 1:02 a.m. - The resident was observed pushing his wheelchair and self down the corridor slowly and then sat him self down. 1/16/16 at 5:22 a.m. The resident was alert and verbally responsive. The resident was noted scooting his body down the hall way to the dining area. Staff asked resident why he was on the floor instead of using the walker the resident replied "I don't know. I like sliding on the floor." The resident scooted back down the hall to his room and got his walker to ambulate with.</p> <p>The 12/2015 Dialysis Communication forms were reviewed. Entries were completed on 12/2/15, 12/8/15, 12/9/15, and 12/11/15. Checking for a thrill and bruit had not been completed with these entries. No further December entries</p>		<p>dialysis days and updating nurses notes accordingly. D.O.N. will monitor residents whoreceive dialysis communication sheet weekly for proper completion for one monththen monthly D.O.N. will monitor nurses notes fordialysis resident will be reviewed weekly for 1 week then monthly. D.O.N. will monitor Care Planinitially to ensure dialysis needs are addressed then quarterlythereafter. D.O.N. will monitor dining room forplacement of all residents at their tables weekly for 1 week then monthly for amonth then quarterly. Q.A. Committee will meet and monitorlogs and determine if further monitoring is needed or revisions to hemodialysiscommunication form and hemodialysis procedures quarterly. F 309B Based on observation, record review and interview, thefacility failed to ensure the necessary treatment and services were attained tomaintain a resident's psychosocial well being, socialization, and selfambulation related to the continued use of a Lab Buddy trunk restraint (paddedcushion extending across the residents waist area). The facility failed to provide adequate chairpositioning devices for 2 of 3 residents who were dependent on staff forpositioning. (Residents #10 and #20) 1.Describewhat the facility did to correct the deficient practice</p>		

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	<p>were made to indicate assessing for a thrill and bruit had been completed.</p> <p>The 1/2016 Dialysis Communication forms were reviewed. Entries were completed on 1/4/16 and 1/6/16. Checking for a thrill and bruit had not been completed on the entries. No further January entries were made to indicate assessing for a thrill and bruit had been completed,</p> <p>The 2/2016 Dialysis Communication forms were reviewed. Entries were completed on 2/1/16 and 2/3/16. Checking for a thrill and bruit to the right arm were not completed on these two days.</p> <p>Review of the 12/2015, 1/2016, and 2/2016 Treatment Administration Records indicated checking for a thrill and bruit had not been recorded during the above months.</p> <p>The 12/2015, 1/2016, and 2/2016 Nurses' Notes were reviewed. Assessments of the dialysis sight for a thrill and bruit were not noted in the above Nurses' Notes.</p> <p>The facility policy titled "Hemodialysis Assessment Policy" was reviewed on 2/3/16 at 1:41 p.m. The policy was dated</p>		<p>for each client cited in the deficiency. Maintenance provided Resident #10 with a wheelchair modified for taller residents. The physical therapist has assessed the resident for appropriate chair to keep him properly positioned. Resident # 10 sits upright in the wheelchair. Resident #20 new geri-chair was received and physical therapist updated positioning and geri-chair needs.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Facility had already identified the need for new geri-chairs but they were backordered and were received and given to residents who required geri-chairs. Maintenance Supervisor was consulted by D.O.N. to see if a wheelchair could be modified for a taller residents use and he was able to modify the wheelchair to meet the needs of Resident #10. All residents in geri-chairs and specialized wheelchairs for proper positioning were reassessed by Physical Therapist.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Staff was in-serviced on proper</p>				

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	<p>12/2012. The Director of Nursing (DoN) provided the policy and indicated the policy was current. The policy indicated the facility was required to communicate with the Dialysis Center via Dialysis Communication sheets. Licensed Nurse were to listen for a bruit and feel for the presence of a thrill each shift. Licensed Nurse were to observe for signs of bleeding.</p> <p>When interviewed on 2/4/16 at 8:15 a.m., RN #1 indicated a Communication Form was to be completed each time the resident goes out for dialysis. The RN indicated the forms were to be sent back with the resident after dialysis.</p> <p>When interviewed on 2/3/16 at 2:50 a.m., the DoN indicated the Hemo-dialysis sheet should have been completed on the day the residents went out for dialysis. The DoN indicated the Nurse's should have followed the facility for assessing for a thrill and bruit every shift. She indicated there should have been a restraint assessment completed. The DoN indicated the resident should not have been placed behind the table with no means to remove himself from the area. The DoN indicated the Lab Buddy was initiated as the resident would slide from his chair when sitting at the table.</p>		<p>positioning and the importance of reporting resident's response to changes in plan of care and reported during 24 hour report. Charge Nurse will continue to monitor wheelchairs and geri-chairs for resident's proper positioning and seating devices daily on monitoring log for each shift. If positioning problem is noted physicians should be notified and Physical Therapist consulted.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Charge Nurse is responsible for monitoring proper positioning and seating devices. This is monitored 12A, 3A, 5A, 8A, 11A, 2P, 4P, 6P, 9P daily by the charge nurse during nurse rounds and recorded on the log sheet. D.O.N. will monitor residents daily for proper seating devices during rounds then monthly. D.O.N. will monitor round sheets bi-weekly for 1 month then monthly thereafter ongoing. Q.A. Committee will meet and monitor logs and determine if further monitoring is needed and discuss any concerns about geri-chairs, wheelchairs and positioning devices for residents.</p> <p>ADDENDUM RESTRAINT FOR RESIDENT WAS DISCONTINUED FOR</p>	

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	<p>2. On 2/1/16 at 10:36 and 10:47 a.m., Resident #10 was observed in his wheelchair at a table in the Dining Room. The resident was observed leaning toward his left side and his left arm was hanging down with his armpit on the arm rest of the wheelchair. There were no cushions or a pillow observed in the wheelchair.</p> <p>On 2/2/16 at 8:10 a.m., 11:08 a.m., and 11:34 a.m., the resident was observed sitting in the wheelchair leaning to the left side. The resident's entire body was leaning to the left side and his armpit was laying on the arm rest of the wheelchair. There was no cushion, padding or pillow observed in the wheelchair.</p> <p>On 2/2/16 at 3:00 p.m. the resident was observed in his room with lights off and the door closed. The resident was leaning to the left side in his wheelchair. There was no staff in the room. There was no pillow, cushion or positioning device observed in the wheelchair.</p> <p>On 2/3/16 at 8:09 a.m., the resident was observed sitting in a wheelchair in the hallway. At that time, he was leaning to the left side and his armpit was resting on the arm rest of the chair. There was no pillow, cushion or positioning device observed in the wheelchair.</p>		<p>RESIDENT #18. ONLY1 RESTRAINT IS CURRENTLY BEING USED TO PROMOTE BODY ALIGNMENT IN THE FACILITY. ALL RESTRAINT USE WAS REVIEWED AND A NEED FOR ONE RESIDENT FOR A THIGH RESTRAINT WAS NEEDED DUE TO HIM KICKING OUT THE SIDES OF THE NEW GERI-CHAIRS PURCHASED FOR HIS USE. HE IS NOW ABLE TO SIT UP RIGHT IN A WHEELCHAIR AND MAINTAIN BODY POSITIONING. THE NEED FOR RESTRAINT IS MONITORED ONGOING BY STAFF. WE ONLY HAVE ONE DIALYSIS RESIDENT AND PROPER FORM USE AND ASSESSMENT IS INDICATED ON MAR.</p>				

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	<p>On 2/3/16 at 1:00 p.m., the resident was observed sitting in his wheelchair in his room by himself. The resident was observed leaning to the left side in the wheelchair, with his left arm hanging over the side. There was no pillow, cushion or positioning device observed in the wheelchair.</p> <p>The record for Resident #10 was reviewed on 2/2/16 at 11:11 a.m. The resident's diagnoses included, but were not limited to, bilateral lower extremity swelling, dementia, failure to thrive, behavioral issues, risk for falls, agitation, altered mental status, epilepsy, and left side weakness.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 11/27/15 indicated the resident was not alert and oriented, and had a Brief Interview for Mental Status (BIMS) of 4. The resident needed limited assist with one person physical assist with transfers, locomotion on and off the unit. The resident had no range of motion limitations to upper and lower extremities. The resident was not steady and required assist with moving from a seated position.</p> <p>The current and updated 11/2015 care plan was reviewed. There was no care</p>			

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	<p>plan for the resident's positioning problem and leaning to the left side.</p> <p>Nursing Notes dated 12/30/15 at 1:32 p.m., indicated the resident had fallen out of his wheelchair and hit the left side of his head on the floor.</p> <p>The investigation of accidents and incidents dated 12/30/15 indicated the possible cause for the accident was "Resident leaned too far in his wheelchair." Evidence that a plan was implemented to prevent further occurrences indicated "Pillow was put in chair on side for leaning."</p> <p>Nursing Notes dated 1/27/16 at 10:41 p.m., indicated resident alert and verbally responsive. Continues to lean to left side in wheelchair. Nursing Notes dated 1/28/16 at 1:50 p.m., indicated resident was alert, but continues to sleep at times. He also continued to favor his left side while in the wheelchair. Nursing Notes dated 1/28/16 indicated the resident was alert. The resident continued to lean to left side. Nursing Notes dated 1/29/16 at 3:30 p.m., indicated the resident continued to lean toward his left side while in wheelchair. A pillow was placed on the left side for support.</p> <p>Continued record review indicated there</p>			

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	<p>were no Physical Therapy Progress Notes for review regarding any positioning device recommendations.</p> <p>Interview with the Director of Nursing on 2/3/16 at 1:39 p.m., indicated there were no Physical Therapy Progress Notes for the resident related to his positioning in the wheelchair. She further indicated the resident was a tall man and did lean to the left side. She indicated the resident needed something to correct his positioning while in the wheelchair.</p> <p>3. On 2/2/16 at 7:52 a.m., 10:59 a.m., 12:20 p.m., and 2:10 p.m., Resident #20 was observed laying in a reclined geri chair. At those times, he was lying on his right side with his legs curled up underneath him. The resident's knees were pushing through the side of the chair. The footrest to the chair was broken and there was a large gaping hole in the chair where the resident's head was. There was no cushion or any other positioning device observed in the chair at those times.</p> <p>On 2/3/16 at 7:45 a.m., and 9:25 a.m., the resident was observed lying the geri chair on his right side. At those times, the resident's knees were pushing through the side of the geri chair and sticking out from the side. There was no cushion or</p>			

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	<p>any other positioning device observed in the chair at those times.</p> <p>On 2/3/16 at 1:10 p.m., the resident was observed lying on his back in a reclined geri chair. The Director of Nursing was notified of the torn and broken geri chair and the way the resident was positioned in the chair.</p> <p>On 2/4/16 at 10:30 a.m., the resident was observed in the dining room seated in a reclined geri chair. At that time, the resident's legs were hanging over the side of the chair. There was no cushion or any other positioning device observed in the chair at that time.</p> <p>The record for Resident #20 was reviewed on 2/3/16 at 8:32 a.m. The resident's diagnoses included, but were not limited to, Huntington's Chorea, agitation with aggressive behavior, anxiety, and muscle weakness.</p> <p>The Quarterly 1/26/16 Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented. The resident needed limited assistance with one person physical assist for bed mobility. The resident needed extensive assistance with one person physical assist for transfer, walk in room, walk in corridor, locomotion on unit and off unit.</p>			

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	<p>The resident had functional limitation of range of motion to both sides of his upper and lower extremities. The resident was not steady and only able to stabilize with staff assistance for moving on and off the toilet, surface to surface transfer, and for turning around and facing in the opposite direction.</p> <p>A Physical therapy Progress Note dated 11/24/15 indicated the patient needed to be up in recliner chair for safety.</p> <p>There were no further Physical Therapy Progress Notes regarding any type of positioning devices for the resident while he was up in the geri recliner.</p> <p>The current and updated 1/2016 care plan indicated the resident had a geri chair for poor trunk control. Another care plan indicated the resident had a regular cushion, wedge cushion, and dycem (a piece of material used to prevent resident's from sliding) to prevent the resident from sliding down in the geri chair. The Nursing approaches were to check the resident's alignment while in chair.</p> <p>Interview the Director of Nursing on 2/3/16 at 1:45 p.m., indicated the resident was very active in his geri chair due to his disease of Huntington's Chorea. She</p>			

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F 0322 SS=D Bldg. 00	<p>further indicated the geri chair was torn in multiple places and a new one had been ordered but had not come in yet. She indicated the resident had not been re-evaluated by therapy for any type of positioning devices while he was in the geri recliner.</p> <p>3.1-37(a)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure the appropriate treatment and services were provide for care of a PEG (Percutaneous Endoscopic Gastrostomy) tubes related to care of the insertion sight and use of a</p>	F 0322	F322 Based on observation, record review, and interview, the facility failed to ensure the appropriate treatment and services were provide for care of a PEG (Percutaneous Endoscopic Gastrostomy) tubes related to care of the insertion sight and use	03/06/2016	

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	<p>binder for 1 of 1 resident reviewed for tube feeding. (Resident #21)</p> <p>Finding includes:</p> <p>On 2/5/16 at 10:30 a.m., RN #2 was observed providing wound care to a pressure ulcer on Resident #21's coccyx area. The resident had a white abdominal binder in place around his abdomen. The Velcro ends of the binder were attached in the back. During the treatment the resident stated the tube was burning. The resident stated this four times during the wound care treatment. The resident also stated the tube hurt him. After the wound care treatment was completed the RN removed the abdominal binder. The PEG tubing was noted to be pulled approximately 1 cm (centimeter) from the insertion site. A roll of pink tissue was observed protruding from the tube insertion site. The RN assessed the insertion site and stated the tube "might have been put on a little too tight."</p> <p>The record for Resident #21 was reviewed on 2/2/16 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, pressure ulcer, and dehydration.</p>		<p>of a binder for 1 of 1 resident reviewed fortube feeding. (Resident #21)</p> <p>1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Resident#21 abdomen binder was discontinued.</p> <p>2.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected. Nooter residents were affected.</p> <p>1.Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. All residents who returnfrom the hospital due to reinsertion of a peg tube will be re-evaluated to seeif abdominal binder is needed. Ifresidents continue to pull at peg tube an order will be secured from thephysician for the binder to be used to discourage dislodgement of pegtube. In-service was held withall nursing staff on care of peg tube site and reporting possible irritation topeg tube site. Licensed Nurses willindicate peg tube treatment on TAR's for residents with includes: Wash peg tube site with soap and water daily. Keep peg tube site clean and</p>		

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	<p>The current Physician orders were reviewed. There were no Physician orders for an abdominal binder to be used. There was no Physician orders for any assessment of the site to be completed or any care to be completed to the insertion site.</p> <p>Review of the 2/016 Medication Records indicated there were no Physician orders related to care of the PEG tube insertion site.</p> <p>The 1/2016 Nursing Notes were reviewed. An entry made on 1/28/16 at 6:30 a.m. indicated the resident had pulled out his PEG tube, and was sent out to the hospital for the PEG tube to be replaced. An entry made on 1/28/16 at 11:00 a.m. indicated the resident had returned from the hospital and his PEG tube had been reinserted and the resident had no complaints of pain or discomfort.</p> <p>When interviewed on 2/3/16 at 12:49 p.m., the Director of Nursing indicated routine care of the PEG was to cleanse the area with soap and water to keep the area clean. The Director of Nursing indicated the above care of the PEG tube was not on the current Treatment Records.</p> <p>3.1-44(a)(2)</p>		<p>dry. Assess peg tube site for/s of infection daily. Charge nurse will monitor TAR's recaps for peg tube care. D.O.N. will monitor pegtube care on TAR's monthly for one month then quarterly thereafter.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Charge nurse will monitor TAR's recaps for peg tube care. D.O.N. will monitor peg tube care on TAR's monthly for one month then quarterly thereafter.</p> <p>Q.A. Committee will be notified of any deficient practices from D.O.N. in regards to peg tube care and determine if further monitoring is needed.</p> <p>ADDENDUM EVERYONE WITH A PEG TUBE HAS THE ABOVE CARE FOR PEGTUBE ADDED TO THEIR TAR. THIS WILL BE MONITORED MONTHLY ON THE RECAPS TO ENSURE IT IS NOT LEFT OFF OF THE TARS AGAIN.</p>	

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F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation and interview, the facility failed to ensure the resident's side rails were secure while in the upright position for 7 beds observed with side rails. The facility also failed to provide adequate supervision related to opening exit doors and opening the fuse box and turning off the facility lights for 1 of 1 residents reviewed for supervision. (Rooms 101, 113 bed 1 and bed 2, and 109 beds 1, 2, and 3 and Resident #18)</p> <p>Findings include:</p> <p>1. On 2/4/16 at 8:30 a.m., the following was observed during Environmental Tour on the East wing:</p> <p>A. The side rails in rooms 101, 113 (both beds) and 109 (three beds) were loose and pulling away from the bed while in the upright position. The side rails, in the upright position, wobbled back and forth and were not secure.</p>	F 0323	<p>F323 A Based on observation and interview, the facility also failed to provide adequate supervision related to opening exit doors and opening the fuse box and turning off the facility lights for 1 of 1 resident reviewed for supervision. (Resident #18)</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Locks were put on all circuit boxes throughout the facility. Resident #18 had never displayed this behavior prior to survey. Staff instructed not to allow anyone into the dining room unless staff is present. Resident's will wait in their rooms or by the nurses station until dining room is opened so that proper supervision is available. Resident # 18 had not exhibited trying to open the door prior to survey.</p> <p>2. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. No other resident exhibits this behavior and behavior had never been displayed prior to survey.</p>	03/06/2016	

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	<p>Interview with the Maintenance Supervisor on 2/4/16 at 8:40 a.m., indicated the side rails were loose and wobbled back and forth. He further indicated they needed to be tightened. He indicated at the time, he was not aware the side rails were loose and wobbled back and forth.</p> <p>2. The record was reviewed for Resident #18 on 2/2/16 at 2:35 p.m. The diagnosis included but were not limited to, anxiety, and dementia with psychotic features.</p> <p>The Quarterly Minimum Data Set (MDS) completed on 1/13/16 indicated that the resident was unable to complete the Brief Interview for Mental Status (BIMS). The care plan indicated the resident had behavior problems, and the interventions included positive interaction, and attention.</p> <p>On 2/3/16 at 6:32 a.m., the resident was observed in his wheelchair in the dining room. The resident was attempting to roll his wheelchair through a door off of the dining room that lead to a short hallway which had a door that exited to the outside. The resident had one hand on the wheel of the wheelchair and the other hand on the door pushing it open. His wheelchair was not able to maneuver around a table sitting close to the door to</p>		<p>Resident has not exhibited behavior of trying to open circuit box or opening kitchen door since survey. No other residents affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>Locks on circuit boxes and door alarm for double exit door by kitchen will be monitored during all shifts. Circuit boxes will be locked at all times. Alarm on exit door will be armed when staff is not in dining room during 9pm to 8am. All nursing staff in-serviced on locked circuit boxes and alarming exit door.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Charge Nurse is responsible for ensuring circuit boxes are locked and door is alarmed from 9pm to 8am daily. Monitoring will be recorded on rounds sheet. D.O.N. will monitor rounds sheets and check circuit box locks and door alarm weekly times one month residents who receive dialysis communication sheet weekly for proper completion for one month then monthly Q.A. Committee will monitor rounds</p>				

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	<p>exit through the door. There was not an alarm sounding and there were no employees in the dining room at this time.</p> <p>On 2/3/16 at 6:40 a.m., the resident was observed opening the unlocked fuse box on the south wall in the dining room and began flipping all the switches on and off. There were no employees in the dining room at this time. The dining room lights and power went out after 2 minutes. The room remained dark until a CNA entered the room 5 minutes later. At that time there were 5 residents sitting in the dining room. The CNA was unable to locate the switch to turn the lights and power back on and left the room to find someone to assist her. The Nurse entered the dining room and 2 minutes later was able to resume power and lighting to the dining room. The resident was then removed from the dining room.</p> <p>On 2/4/16 at 1:13 p.m., the Social Service Designee indicated, that the door off of the kitchen had an alarm. There was also a sign posted outside the door that reads "do not turn off alarm". She further indicated that the alarm was loud and was able to be turned off manually on the inside of the door frame, but should not be turned off. The hallway has</p>		<p>logsand determine if further monitoring is needed and if changes need to be made todoor alarm system quarterly.</p> <p>F 323 B Based on observation and interview, the facility failedto ensure the resident's side rails were secure while in the upright positionfor 7 beds observed with side rails. (Rooms 101, 113 bed 1 and bed 2, and 109 beds 1, 2, and 3)</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency. Side rails in rooms 101, 113, and 109 side railswere secured with additional bolts.</p> <p>2.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p>All side railsthroughout the facility were reinforced with additional bolting to the bedframe by maintenance department.</p> <p>1. Describe the steps or systemic changes thefacility has made or will make to ensure that the deficient practice does notrecur, including any in-services, but this also should include any systemchanges you made.</p> <p>Maintenance departmentwill check all bed rails weekly for loose bed rails. All nursing staff andmaintenance staff will be in-serviced on monitoring side rail for looseness andreporting it to the maintenance staff.</p> <p>1.Describe how the corrective</p>				

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	<p>an exit door that goes to the outside. She indicated she was not sure why the alarm was off.</p> <p>The Social Service Designee, indicated that the fuse box in the dining room controls the lighting and power to the dining room and chapel only.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance department will complete log for side rail safety and indicate repairs.</p> <p>Charge Nurse is responsible for reporting malfunctions in siderail equipment to maintenance department and D.O.N. D.O.N. will monitor maintenance logs and side rail repairs weekly for one month then monthly for one month then quarterly thereafter.</p> <p>Q.A. Committee will monitor repair logs and determine if further monitoring is needed and if changes need to be made quarterly.</p> <p>ADDENDUM IN-SERVICE WAS HELD WITH ALL STAFF ABOUT RESIDENT SAFETY AND NEW MEASURES FOR LOCKING CIRCUIT BOXES AND DOOR ALARMS. DINING ROOM HOURS ARE FROM 8:00AM – 9:00PM. NO RESIDENTS ARE ALLOWED IN THE DINING ROOM UNLESS STAFF IS IN THAT AREA FOR SUPERVISION.</p> <p>ADDENDUM STAFF WAS IN-SERVICED ON SAFETY AND SIDE RAILS. NEW SECURING MEASURES WERE IMPLEMENTED AND ADDITIONAL SIDE RAILS HAVE BEEN ORDERED BUT HAVE NOT ARRIVED. ONCE NEW SIDE RAILS HAVE BEEN</p>		

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F 0325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure nutritional supplements were provided as ordered for 1 of 3 residents reviewed for Nutrition of the 3 residents who met the criteria for Nutrition. (Resident #18)</p> <p>Finding includes:</p> <p>The record for Resident #18 was reviewed on 2/2/16 at 2:35 p.m. The</p>	F 0325	<p>RECEIVED FROMVENDOR THEY WILL BE APPLIED TO THE BEDS. THE SIDE RAILS MONITORED WEEKLY BY MAINTENENCE STAFF. SIDE RAILS ARE MONITORED BY NURSING STAFF ON ALLSHIFTS. SECURE SIDE RAIL USAGE WILL BE MONITORED ONGOING.</p> <p>F 325 Based on observation, record review, and interview, thefacility failed to ensure nutritional supplements were provided as ordered for1 of 3 residents reviewed for Nutrition of the 3 residents who met the criteriafor Nutrition. (Resident #18)</p> <p>1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Resident#18 primary source of nutritional intake is orally.</p>	03/06/2016	

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	<p>resident's diagnoses included, but were not limited to, end stage renal disease, anemia, high blood pressure, diabetes mellitus.</p> <p>The 2/2016 Physician Order Sheet indicated the resident was to have a regular diet with double protein at breakfast and dinner. There were no Physician orders for liquid nutritional supplements noted.</p> <p>A hand written prescription was noted in the resident's record. The prescription was signed by a Physician. The prescription was for the resident to receive Nephro (a liquid nutritional supplement) one (8) ounce can daily.</p> <p>When interviewed on 2/3/16 at 2:30 p.m., the Director of Nursing indicated the resident had not been receiving the Nephro. The Director of Nursing indicated the order had been written on a prescription and not addressed.</p> <p>3.1-46(a)(1)</p>		<p>Dialysis physician prescribed Neprosupplement 1 can daily. D.O.N.interviewed nursing staff and proper procedure was not followed in securingphysician orders. The supplement wasadministered to the resident on non-dialysis days and sent with him duringdialysis. Dialysis unit stopped givingresident supplement because he would be incontinent of stool at the dialysisunit and had to be returned to the facility and dialysis rescheduled. Neprosupplement was discontinued per dialysis request and physician.</p> <p>2.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected. No oneaffected from this finding.</p> <p>1.Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. D.O.N. reviewed procedurefor securing physician orders and placing new orders on MAR with licensednursing staff. Communication of neworders will be indicated on 24 hour report and in nurses documentation.</p> <p>1.Describe how the corrective action(s) will be monitored to</p>		

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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Charge Nurse will beresponsible properly documenting new physician orders and place on shift toshift report. D.O.N. will review alldiet orders and supplements monthly. Dietician will review allresidents diet orders monthly. Q.A. will review DietaryCommunication Sheets for changes in diet and supplement use quarterly anddetermine if further need of monitoring is needed.</p> <p>ADDENDUM NO RESIDENTS ARE ONSUPPLEMENTS NO MONITORING NEEDED</p>	

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	<p>documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to follow Physician Orders related to the completion of labs for 1 of 5 residents reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Resident #10)</p> <p>Finding includes:</p> <p>The record for Resident #10 was reviewed on 2/2/16 at 11:11 a.m. The resident's diagnoses included, but not limited to, bilateral lower extremity swelling, congestive heart failure, dementia, vitamin b deficiency, pancreatitis, failure to thrive, malnutrition, high blood pressure, Benign Prostatic Hyperplasia (BPH) and epilepsy.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 11/27/15 indicated the resident was not alert and oriented, had a Brief Interview for Mental Status (BIMS) score of 4. The resident received a diuretic medication for 7 days during the observation period.</p>	F 0329	<p>F 329 Based on record review and interview the facility failed to follow Physician Orders related to the completion of labs for 1 of 5 residents reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Resident #10)</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #10 Nurse notified the physician and labs were rescheduled and drawn from resident who was cooperative</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No other residents affected.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Licensed Nursing Staff was in-serviced on proper procedures for securing labs for residents who have refused. 1. Notify the</p>	03/06/2016

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	<p>Physician Orders dated 3/6/15 and on the current 2/2016 recap indicated Lasix (a diuretic medication) 40 milligrams (mg) daily.</p> <p>A Physician Order dated 12/30/15 indicated to hold Lasix 40 mg times 3 days. Give Lasix 80 mg daily times 3 days. Have a BMP (Basic Metabolic Panel) lab draw on 1/6/16. Resume Lasix 40 mg on 1/2/16.</p> <p>The laboratory section in the medical record was reviewed. There was no BMP obtained on or around 1/6/16.</p> <p>Another Physician Order dated 1/20/16 indicated obtain labs of Vitamin D, PSA (Prostate Specific Antigen), A1c (Glycated hemoglobin, a blood test to determine blood sugar levels over months), Homocysteine level (a blood test to determine the amount of amino acid in the blood) and a Zinc level.</p> <p>The laboratory section in the medical record was reviewed. There was no evidence the above mentioned labs were obtained as ordered by the Physician.</p> <p>The lab agency was notified by LPN #1 on 2/2/16 at 2:30 p.m. The lab provided documentation as follows: On 1/6/16 the lab attempted to draw the BMP, however,</p>		<p>physician, 2. Notify the family, 3. Reschedule lab draw. 4. If resident still refuses the physician will be consulted and indicate new orders. All lab refusals will be documented in the nurses notes and shift to shift report during 24 hour report. A copy of all lab refusals requisitions will be reported to D.O.N. D.O.N. will monitor lab refusals to ensure labs are rescheduled and discuss problems during Q.A.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Midnight Charge Nurse is responsible for all monitoring lab orders and providing a copy of a lab refusal to the D.O.N. Midnight Charge Nurse will notify physician, receive new orders, notify family member of the lab refusal. Midnight Charge Nurse will be responsible for rescheduling the ordered lab or discontinuation of the lab per physician's orders. D.O.N. will monitor lab draws audits sheets monthly to ensure labs are drawn as prescribed by physician. D.O.N. will monitor lab refusals as they occur ongoing. Q.A. Committee will meet and monitor lab audits and refusal lab logs and determine if further monitoring is needed.</p> <p>ADDENDUM ALL OF OUR RESIDENTS</p>		

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	<p>the resident refused. On 1/23/16 the lab attempted to draw the Glycated Hemoglobin, Homocyteine, PSA, and Vitamin D levels, however, the resident refused.</p> <p>Nursing Notes were reviewed from 1/6/16 to 2/2/16 and there was no documentation the resident refused the lab draw or the Physician was notified of the refusals.</p> <p>A Physician Progress Note by the Physician dated 1/28/16 indicated "Patient is having his head down, staff have discussed with (Physician name). Recommend: Get labs done."</p> <p>Interview with LPN #1 on 2/2/16 at 2:47 p.m., indicated the resident had refused the lab draws, however, there was no documentation in the Nurse's Notes. She further indicated the resident's Physician had not been notified of the refusals and no labs had been drawn for the resident.</p> <p>The LPN #1 on 2/3/16 at 1:36 p.m., indicated all of the labs that had been previously ordered were drawn today.</p> <p>3.1-48(a)(3)</p>		EXCEPT FOR 3 WERE REVIEWED DURING THE SURVEY AND THOSE 3 RESIDENTS ARE COMPLIANT WITH LAB DRAWS. LAB AUDITS ARE PERFORMED BY METHODIST HOSPITAL AND NO ONE ELSE REFUSED LABS.		

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F 0332 SS=D Bldg. 00	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 7 residents observed during medication pass. Two medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 7.69%. (Residents #13 and #9)</p> <p>Findings includes:</p> <p>1. On 2/2/16 at 7:59 a.m., RN #1 was observed preparing an Insulin injection for Resident #13. The Nurse indicated since the resident's blood sugar was 167 per the Accucheck, he received 2 units of Insulin per sliding scale and he received 8 units of the same Insulin before each meal as a scheduled dose. At that time, she drew up 10 units of Novolog Insulin (a fast acting Insulin) into a syringe. She then administered the Insulin injection into the resident's abdomen. Continued observation indicated the Nurse did not offer a snack to the resident and breakfast was not ready.</p> <p>On 2/2/16 at 8:47 a.m., the resident was</p>	F 0332	<p>F 332 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 7 residents observed during medication pass. Two medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 7.69%. (Residents #13 and #9)</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Medication error reviewed with RN #1 and review of Novolog insulin (fast acting insulin) administration and food administration. Medication error reviewed with RN #1 of Tylenol administration and reading medication sheet.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No other residents affected from this finding.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not</p>	03/06/2016			

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	<p>observed in the dining room. At that time, he received his breakfast tray.</p> <p>Interview with the resident at that time, indicated he had not eaten anything since last night's dinner.</p> <p>The record for Resident #13 was reviewed on 2/3/16 at 10:56 a.m. The resident's diagnoses included, but were not limited to, diabetes.</p> <p>The current Physician Orders on the 2/2106 recap indicated Novolog Insulin inject 8 units three times a day daily before meals scheduled for 8 a.m. Another Physician Order for sliding scale Insulin indicated Novolog if blood sugar 150-200-give 2 units.</p> <p>"How Novolog Works" was retrieved on 2/3/16 at 11:30 a.m., from the Novolog website (Novolog.com), the guidance indicated "As an insulin that you take at mealtime, Novolog is often called mealtime or bolus insulin. Because it goes to work quickly, it is also sometimes called rapid-acting or fast-acting insulin. And, because it is a slightly changed man-made version of insulin, it is also called analog insulin. As a fast-acting insulin analog, Novolog acts quickly, so you must eat within 5 to 10 minutes after taking it." (sic)</p>		<p>recur, including any in-services, but this also should include any system changes you made.</p> <p>D.O.N. reviewed medication administration and insulin administration with RN #1. Insulin chart was in-serviced with all licensed nurses and made part of the orientation binder. Morning snack will be given during administration of rapid acting and short acting insulin. Insulin Chart The chart below lists the types of injectable insulin with details about onset (the length of time before insulin reaches the bloodstream and begins to lower blood sugar), peak (the time period when it best lowers blood sugar) and duration (how long insulin continues to work). These three things may vary. The final column offers some insight into the "coverage" provided by the different insulin types in relation to mealtime.</p> <p>Type of Insulin & Brand Names Onset Peak Duration Role in Blood Sugar Management</p> <p>Rapid-Acting Lispro (<u>Humalog</u>) 15-30 min. 30-90 min 3-5 hours Rapid-acting insulin covers insulin needs for meals eaten at the same time as the injection. This type of insulin is often used with longer-acting insulin.</p> <p>Aspart (<u>Novolog</u>) 10-20 min. 40-50 min. 3-5 hours Glulisine (<u>Apidra</u>) 20-30 min. 30-90 min. 1-2½ hours</p>				

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	<p>Interview with the Director of Nursing on 2/3/16 at 3:05 p.m., indicated the nurse should have given him something to eat after the insulin administration.</p> <p>2. On 2/2/16 at 8:19 a.m., RN #1 was observed pouring medication for Resident #9. At that time, she was observed to place Acetaminophen 500 milligrams (mg) 2 tablets into the medication cup. The Nurse then administered the medication to the resident and left the room.</p> <p>The record for Resident #9 was reviewed on 2/3/16 at 9:25 a.m.</p> <p>Physician Orders on the current 2/2016 recap indicated Acetaminophen 500 mg 1 tablet twice a day.</p> <p>Interview with the Director of Nursing on 2/3/16 at 3:07 p.m., indicated the nurse should have given the resident only 1 Acetaminophen tablet rather than 2.</p> <p>3.1-25(b)(9)</p>		<p>Short-Acting Regular (R) <u>Humulin</u> or novolin 30 min. -1 hour 2-5 hours 5-8 hours Short-acting insulin covers insulin needs for meals eaten within 30-60 minutes. <u>Velosulin</u> (for use in the <u>insulin pump</u>) 30 min.-1 hour 2-3 hours 2-3 hours</p> <p>Intermediate-Acting NPH (N) 1-2 hours 4-12 hours 18-24 hours Intermediate-acting insulin covers insulin needs for about half the day or overnight. This type of insulin is often combined with a rapid- or short-acting type.</p> <p>Long-Acting Long-acting insulin covers insulin needs for about one full day. This type is often combined, when needed, with rapid- or short-acting insulin. Insulin glargine (<u>Lantus</u>) 1-1½ hour No peak time. Insulin is delivered at a steady level. 20-24 hours Insulin detemir (<u>Levemir</u>) 1-2 hours 6-8 hours Up to 24 hours</p> <p>Pre-Mixed* Humulin 70/30 30 min. 2-4 hours 14-24 hours These products are generally taken two or three times a day before mealtime. Novolin 70/30 30 min. 2-12 hours Up to 24 hours Novolog 70/30 10-20 min. 1-4 hours Up to 24 hours Humulin 50/50 30 min. 2-5 hours 18-24 hours Humalog mix 75/25 15 min. 30</p>	

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			<p>min.-2½ hours 16-20 hours</p> <p>*Premixed insulins combine specific amounts of intermediate-acting and short-acting insulin in one bottle or insulin pen. (The numbers following the brand name indicate the percentage of each type of insulin.)</p> <p>All medication protocols reviewed with RN #1</p> <p>8 Rights Of Medication Administration Chances are that some of you may not have known that in addition to the well-known 5 right of medication administration, some experts have added 3 more to the list. When it comes to patient safety, it's never a bad time to review some of the basics and increase your awareness of newer recommendations. Please add any of your own tips and medication safety advice by leaving a comment. Thanks!</p> <p>Rights of Medication Administration</p> <p>1. Right patient</p> <ul style="list-style-type: none"> · Check the name on the order and the patient. · Use 2 identifiers. · Ask patient to identify himself/herself. · When available, use technology (for example, bar-code system). <p>2. Right medication</p> <ul style="list-style-type: none"> · Check the medication label. · Check the order. 3. Right dose · Check the order. · Confirm appropriateness of the dose using a current drug 	

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			<p>reference.</p> <ul style="list-style-type: none"> ·If necessary, calculate the dose and have another nurse calculate the dose as well. 4.Right route ·Again, check the order and appropriateness of the route ordered. ·Confirm that the patient can take or receive the medication by the ordered route. 5.Right time ·Check the frequency of the ordered medication. ·Double-check that you are giving the ordered dose at the correct time. ·Confirm when the last dose was given. 6.Right documentation ·Document administration AFTER giving the ordered medication. ·Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7.Right reason ·Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? ·Revisit the reasons for long-term medication use. 8.Right response ·Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? ·Be sure to document 	

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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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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		your monitoring of the patient and any other nursing interventions that are applicable. Medication pass performed by D.O.N. with RN #1. Pharmacist consultant will schedule a medication pass observation with RN #1. 1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Pharmacy Consultant will monitor medication pass with all nurses quarterly. D.O.N. will perform medication pass with all nurses RN #1 and newly hired nurses monthly for 1 month then quarterly thereafter. Q.A. Committee will meet and review medication pass results and determine if further monitoring is needed. ADDENDUM NO OTHER ERRORS NOTED MEDICATION PASS IS PERFORMED WITH D.O.N. OR PHARMACIST CONSULTANT. THIS IS ON-GOING EVERY QUARTER.	

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	<p>Based on observation, record review, and observation the facility failed to store and prepare food under sanitary conditions related to opened foods not dated, an accumulation of grease on the stove, and spillage on the counters for 1 of 1 kitchens located in the facility. (The Main Kitchen) The facility failed to ensure sanitary procedures were followed related to maintaining the correct strength of sanitizing solutions and dishwasher temperatures. Also the facility failed to ensure foods were served under sanitary conditions related to staff touching residents food during meal time, and plastic reusable tray cards and metal stands during tray line service. These deficient practices had the potential to affect 14 of 17 residents who received oral diets.</p> <p>Findings include:</p> <p>1. During the brief initial Kitchen Sanitation Tour on 2/1/16 at 8:50 a.m., the following was observed:</p> <p>a. There was dried spillage on the hand washing sink and the wall behind the sink.</p> <p>b. There was dust and crumbs on the metal shelf table next to the stove. A toaster was on a platter on the table.</p>	F 0371	<p>F371</p> <p>Based on observation, record review, and observation the facility failed to store and prepare food under sanitary conditions related to opened foods not dated, an accumulation of grease on the stove, and spillage on the counters for 1 of 1 kitchens located in the facility. (The Main Kitchen) The facility failed to ensure sanitary procedures were followed related to maintaining the correct strength of sanitizing solutions and dishwasher temperatures. Also the facility failed to ensure foods were served under sanitary conditions related to staff touching residents food during meal time, and plastic reusable tray cards and metal stands during tray line service. These deficient practices had the potential to affect 14 of 17 residents who received oral diets.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>The dried spillage on the wall by the hand washing sink was cleaned by the maintenance staff.</p> <p>The dust and bread crumbs on the metal shelf table next to the stove and toaster was cleaned from toast prepared for morning breakfast.</p> <p>The coffee machine spillage and coffee grounds were cleaned</p>	03/06/2016			

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	<p>There was an accumulation of crumbs on the platter.</p> <p>c. The coffee machine was on a platter on the shelf across from the tray line. Coffee spillage and coffee grounds were on the platter.</p> <p>d. There were several open bags of food in the walk in cooler. The foods were not dated with the dates they were first opened or cooked. The food items included an open bag of shredded cheese, two open bags of bread, two open bags of hamburger buns, a large container of mayonnaise, two large pieces of cooked ham, an open bag of lettuce, an open jar of jelly, a roll of liver sausage, and two bags of cooked ham.</p> <p>e. There were several opened bags of frozen food in the small flip up freezer by the end of the tray line. The foods were not dated with the dates they were first opened. The food items included, open bags of chicken breasts, sausage patties, sausage links, hamburger, and vegetables.</p> <p>f. There was an open plastic container of milk in the reach in cooler behind the tray line. The milk carton had a "best by " date of 1/22/16. There were two plastic bins of fruit in syrup without dates</p>		<p>from morningbreakfast.</p> <p>Thekitchen white floor pipes under 3 compartment sink to dishwasher wereimmediately cleaned of the dust, grease and debris by maintenance staff.</p> <p>Allunlabeled food items were disposed of immediately.</p> <p>D.O.N.immediately reviewed the Quats and Chlorine procedure for testing ppms. New test strips were purchased and date of stripswas added to daily log sheets.</p> <p>Thedishwasher temp does reach 120 degrees but it must run 5 times prior to firstwash for the water to reach from the basement to the kitchen since thedishwasher is a low temp and does not have a heater booster attached. Dishwasher did reach the required temp.</p> <p>RN #2notified C.N. a.#5 of her deficient practice of touching a resident'sfood. D.O.N. was informed of thedeficiency in-service was reviewed with C.N.A. avoid bare hand contact withfood at meal service glove technique was included along with proper handwashing technique.</p> <p>2.Describe how the facility reviewed all clients in the</p>		

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	<p>2. During the full Kitchen Sanitation tour on 2/4/16 at 10:25 a.m., the following was observed:</p> <p>a. Cook #1 was preparing a sanitation bucket. The Cook poured one capful of bleach in the bucket. The Cook then attempted to test the concentration level of the solution. The Cook tore off tape off a roll of Quat (Quatiternary) strips. The expiration date on the container read 8/2014. The strip turned a yellow color and did not match any of color codes on the Quat strip container. The Cook states she prepared the bucket and sink using bleach.</p> <p>b. Cook #1 also ran trays through the dishwasher. There was only one dial/temperature on the machine. The label on the dishwasher temperature dial indicated the temperature was required to be at least 120 degrees Fahrenheit.</p> <p>3. The Nourishment refrigerator was observed on 2/15/16 at 9:45 a.m. There were four individual containers of honey thickened consistency Thick and Dairy beverages in the refrigerator. The cartons had expiration dates of 6/24/14 on them.</p> <p>When interviewed on 2/1/16 a 9:00 a.m., Cook #1 indicated open bags of food were to be dated. The Cook indicated the</p>		<p>facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected.</p> <p>Noother deficient practices noted at this time.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-services held withdietary, nursing and maintenance department held. In-Service included: Avoid Bare Hand Contact With Food At MealService, Hand washing, Sanitizer Use, Glove Use, Dietary & DepartmentCleaning Log, Temperatures for FoodSafety, Temp log forms for refrigerators, freezer, dishwasher, food temps,proper food labeling and storage. Dietician will in-servicethe staff on survey findings upon her next visit and complete Dietary Safetyand Sanitation Form for Administrator review. MaintenanceIn-Service: Daily cleaning log forkitchen which was updated to include cleaning pipes, sanitizing solutioncontainers, and wall of employee hand washing sink.</p> <p>1. Describe how the corrective</p>	

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	<p>dishwasher was suppose to have reached 120 degrees for both the wash and the rinse cycles.</p> <p>4. In the Dining room on 2/5/16 at 8:51 a.m., CNA # 5 was observed picking up Residents #18 toast to spread jelly on it with her bare hands.</p> <p>Interview with Registered Nurse #2 at that time, indicated she was not suppose to touch any food with her bare hands.</p> <p>3.1-21(i)(3)</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Administrative Designee will monitor dishwasher temps , assess Quats and Chlorine testing, Proper Food Temps, Cleaning logs and assess cleanliness of kitchen 4 days a week for the first month then monthly until Q.A. has evaluated logs.</p> <p>Monitor Tray line and complete Tray Line Audit Tool daily times one month then monthly 1 until Q.A. has evaluated logs.</p> <p>Administrator will perform Tray Line Audit Tool 3 times a week for one week then weekly for 6 months. Q.A. Committee will review Audit Tools and determine frequency of further monitoring.</p> <p>Administrative Designee will monitor custodial cleaning log of kitchen daily and check for dust, grease and debris in the cited areas and throughout entire kitchen area.</p> <p>Dietician will complete Dietary Safety and Sanitation Form and proper labeling of food and monitoring for expired testing strips and food items upon each visit and notify Administrator of concerns.</p> <p>Q.A. Committee will review all logs from Dietary Logs, Tray Line Audit Log, Dietician Report (Dietary Safety and Sanitation Form) and Maintenance Log</p>	

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F 0406 SS=D Bldg. 00	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation and record review, the facility failed to ensure Physical Therapy was provided as per the Physical Therapist recommendations for 1 of 1 residents reviewed for Rehabilitation. (Resident #21)</p> <p>Finding includes:</p> <p>On 2/2/16 at 11:52 a.m., Resident #21 was observed in a wheel chair. A Lap Buddy cushion was in place.</p> <p>The record for Resident #21 was reviewed on 2/2/16 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, pressure ulcer, and</p>	F 0406	<p>(Custodial Daily Log ForKitchen and determine frequency of further monitoring.</p> <p>F 406 Based on observation and record review, the facility failed to ensure Physical Therapy was provided as per the Physical Therapist recommendations for 1 of 1 residents reviewed for Rehabilitation. (Resident#21)</p> <p>1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. Resident#21 order for P.T. was discussed with Physical Therapist. It was discovered that the Physical Therapisthad an emergency and had to leave for Egypt due to sickness in his family. When he returned 1/15/16 the resident was inthe hospital and the P.T. order was not continued.</p> <p>2.Describe how the facility reviewed all clients in the</p>	03/06/2016

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	<p>dehydration.</p> <p>A Physical Therapy Progress note was completed on 12/10/15. The note indicated a skilled care summary had been completed. The summary indicated a safety self release belt was to be used when the resident was up in the wheelchair. The note also indicated Physical Therapy was to continued as planned. No further Physical Therapy notes were completed related the resident receiving any further Physical Therapy.</p> <p>3.1-23(a)(1)</p>		<p>facilitythat could be affected by the same deficient practice, and state, what actionthe facility took to correct the deficient practice for any client the facilityidentified as being affected. No oneelse was affected.</p> <p>1.Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. The Physical Therapistwill complete a log sheet for P.T. visits which will include the P.T. order thestart date, end date and visits along with minutes, and progress notes. This log will be completed by the PhysicalTherapist and reviewed weekly by the D.O.N. and MDS Coordinator and used duringMDS meetings and Care Conferences. Thiswill ensure all staff is aware of who is receiving therapy services.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Physical Therapist willcomplete P.T. log sheet upon each visit. P.T. log sheet will be reviewed by D.O.N. or designee weekly forone month then monthly thereafter. Q.A. will monitor P.T.logs quarterly and determine if any problems with current monitoring</p>		

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F 0412 SS=D Bldg. 00	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review, and interview, the facility failed to ensure dental services were provided for 1 of 3 residents reviewed for dental service of the 3 residents who met the criteria for dental services. (Resident #21)</p> <p>Finding includes:</p> <p>On 2/1/16 at 11:37 a.m., Resident #21 resident was observed in his room. The resident did not have any natural teeth or dentures in place.</p> <p>The record for Resident #21 was reviewed on 2/2/16 at 1:51 p.m. The resident's diagnoses included, but were</p>	F 0412	<p>system of physical therapy services being provided to residents.</p> <p>ADDENDUM MONITORING WILL BE ONGOING QUARTERLY</p> <p>F 412 Based on observation, record review, and interview, the facility failed to ensure dental services were provided for 1 of 3 residents reviewed for dental service of the 3 residents who met the criteria for dental services. (Resident #21)</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Social Service Designee was mistaken. D.O.N. provided the schedule of residents who were seen by the dentist that included Resident #21. The Dentist was contacted but she was out of the country and was unable to email the dental visit note, however when</p>	03/06/2016

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	<p>not limited to, dementia with behavioral disturbances, anxiety, pressure ulcer, and dehydration.</p> <p>The Progress Notes were reviewed. There were no Dental Progress Notes completed.</p> <p>When interviewed on 2/3/15 at 2:30 p.m., the Social Service Designee indicated there were no Dental visit notes for the resident.</p> <p>3.1- 24(a)(1)</p>		<p>she returned the dental note was sent to the facility.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No one was affected since every resident has been evaluated by the dentist in a timely manner.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. No systemic changes will be made but a copy of the dental visits will be kept by social service for 1 year for referral so that it will be available for surveyors review.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Social Service will ensure dental visit reports are on the chart.</p> <p>·ADDENDUM ALL RESIDENTS RECEIVED TIMELY DENTAL EXAMINATIONS BY THE DENTIST WE WERE NOT DEFICIENT IN THIS PRACTICE. MONTHLY DENTAL VISITS SCHEDULE WILL BE KEPT FOR A YEAR FOR REVIEW.</p>		

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F 0431 SS=E Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>		THE SYSTEM WILL BE MONITORED FOR THE FIRST QUARTER AND Q 6 MONTHS THEREAFTER.	

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	<p>Based on observation, record review, and interview, the facility failed to ensure medications were labeled when opened and the medication room was unlocked when unattended for 1 of 1 medication rooms.</p> <p>Findings include:</p> <p>1. On 2/1/16 at 3:05 p.m., there was a Victoza (a medication used for glycemic control) injection pen observed in the medication refrigerator. The pen was opened, however, there was no date on the pen as to when it was opened.</p> <p>Interview with LPN #2 on 2/1/16 at 3:17 p.m., indicated the injectable pen should have been dated after it was opened. Further interview with LPN #2 at that time, indicated she had verified with the midnight nurse and the pen was opened earlier that morning.</p> <p>2. On 2/2/16 from 8:00 a.m. to 8:29 a.m., RN #1 was observed on the West wing passing medications. At that time, the medication room located behind the Nurse's station was unlocked and unattended. There was no staff around Nurse's station. There was a blue plastic container located inside the medication room that was full of oral and liquid medications. There was also an</p>	F 0431	<p>F 431 Based on observation, record review, and interview, the facility failed to ensure medications were labeled when opened and the medication room was unlocked when unattended for 1 of 1 medication rooms</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. L.P.N.#2 secured information of when injectable pen was opened from night nurse and it was labeled properly. D.O.N. in-service nurses on keeping medication room locked..</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No one was affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Licensed Nurses will daily check to ensure all insulin is dated when opened. Pharmacist Consultant will monthly monitor insulin products to ensure they are dated when opened. She will make D.O.N. aware of any deficient practice. D.O.N. will review logs and pharmacy report monthly.</p>	03/06/2016			

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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	
	<p>Emergency Drug Kit (EDK) box located inside the med room.</p> <p>On 2/2/16 at 9:00 a.m., RN #1 had pushed her medication cart into the dining room and was observed passing medications to the residents. At that time, the medication room was still unlocked and unattended.</p> <p>On 2/3/16 from 5:20 a.m. until 5:35 a.m., the medication room was again unlocked and unattended.</p> <p>On 2/3/16 at 10:20 a.m. until 10:40 a.m., the medication room was observed unlocked and unattended. There were residents observed seated around the Nurse's station as well as residents ambulating by the Nurse's station. At that time, there was a plastic blue tub of oral and liquid medications noted in the med room. The blue tub was unlocked. The EDK box was also observed in the room.</p> <p>Interview with the Director of Nursing on 2/3/16 at 3:45 p.m., indicated the medication room should be locked at all times while unattended.</p> <p>3.1-25(m)</p>		<p>Medication doors will be changed to self-closing and locking doors to ensure medication remains secure at all times.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Q.A. will monitor pharmacist consultant reports and nursing logs to ensure insulin is dated when opened. Q.A. will evaluate self-closing and self-locking of medication room doors to ensure it prevents deficient practices of leaving medication room unlocked while unattended. Q.A. Committee will determine the need to increase or decrease monitoring after assessment of effectiveness of deficient practice correction.</p> <p>ADDENDUM ALL MEDICATIONS FOR MULTI-USE WERE CHECKED TO ENSURE THEY WERE PROPERLY LABELED AND DATED WHEN OPENED. THIS IS MONITORED BY THE CHARGE NURSE ONE EVERY SHIFT. THIS WILL BE MONITORED ONGOING BY THE PHARMACIST CONSULTANT MONTHLY. D.O.N. WILL MONITOR ONGOING MONTHLY.</p>		

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F 0441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>			
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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure hand washing was completed after glove removal during medication pass for 1 of 7 residents observed during med pass. The facility also failed to ensure new employees received a second step tuberculin skin test for 1 of 10 employee files reviewed. (Resident #3)</p> <p>Findings include:</p> <p>1. On 2/3/16 at 10:40 a.m., LPN #1 was observed preparing to administer eye drops to Resident #3. At that time, the LPN washed her hands with soap and water and donned a clean pair of gloves to both of her hands. She administered both eye drops and removed her gloves and threw them away. The LPN then signed for the medications in the med book. She did not wash her hands with soap and water or use an alcohol gel after removing the gloves. The LPN helped the resident out of the medication room by pushing her wheelchair. At that time, 2 new employees came into the medication room to get their blood pressure checked. The LPN proceeded to take both employee's blood pressure and still had not washed her hands with soap and water or used alcohol gel. The LPN</p>	F 0441	<p>F 441 Based on observation, record review and interview, the facility failed to ensure hand washing was completed after gloveremoval during medication pass for 1 of 7 residents observed during medpass. The facility also failed to ensure new employees received a second step tuberculin skin test for 1 of 10 employeefiles reviewed. (Resident #3)</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency. Handwashingpolicy reviewed with L.P.N. #1 Newtracking system for new employees developed to ensure 2nd stepMantoux if given.</p> <p>2.Describehow the facility reviewed all clients in the facility that could be affected bythe same deficient practice, and state, what actions the facility took tocorrect the deficient practice for any client the facility identified as beingaffected. No otherresidents or staff was affected.</p> <p>3.Describethe steps or systemic changes the facility has made or will make to ensure thatthe deficient practice does not recur , including any in-services, but thisalso should include any system changes you made. HandwashingIn-Service was provided to all nurses. PharmacistConsultant will perform medication pass</p>	03/06/2016			

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	<p>finished taking the blood pressures and then walked out of the medication room.</p> <p>Interview with LPN #1 on 2/3/16 at 11:10 a.m., indicated she did not wash her hands after she removed her gloves or before she took the blood pressure of the new employees.</p> <p>Interview with the Director of Nursing on 02/04/2016 3:50:42 PM indicated the nurse should have washed her hands with soap and water</p> <p>The current and undated Hand Washing Policy indicated "Indications for anti-bacterial soap and water hand hygiene-after glove removal."</p> <p>2. The employee files were reviewed on 2/4/16 at 2:30 p.m. CNA #1 was hired on 6/10/15 and the first step Tuberculin skin test was completed on 5/29/15. There was no second step Tuberculin skin test completed.</p> <p>Interview with the Social Service Designee on 2/4/15 at 3:30 p.m., indicated a second step tuberculin skin test had not been done for the CNA.</p> <p>The current 9/1/15 Pre-Employment Physical policy provided by the Director of Nursing on 2/5/16 indicated "The</p>		<p>observations monthly with licensednurses. A log book will be set up for all current employeesand employees hired in the last 120 days a PPD 1st step and 2ndstep or chest x-ray.</p> <p>4.Describe how the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place. D.O.N.will assess handwashing of nurses during medication pass and record onmedication pass evaluation performance review. Officemanager will be responsible for keeping book updated as new employees arehired. Administrator and D.O.N.will review all personnel records before a new hire is scheduled andsemi-annually. Q.A. Committee will review new hirebinder which will include but not limited to physical, mantoux 1stand 2nd step. Q.A. Committee will reviewmedication pass documentation from pharmacist consultant and D.O.N. Q.A. will determine if furthermonitoring is needed.</p> <p>ADDENDUM C.N.A. #1 HAD THE 1ST AND 2NDSTEP PPD COMPLETED PROPER HANDWASHING TECHNIQUE WILL BE MONITOREDON ALL SHIFTS WHICH WILL BE MONITORED ONGOING BY THE CHARGE NURSE. MONTHLY BY THE D.O.N. FOR 1 MONTH</p>				

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F 0460 SS=D Bldg. 00	<p>physical exam must include a test for tuberculosis within 6 months. It is also required for you to have a 2nd step PPD performed within a month of your employment."</p> <p>3.1-14(t)(1) 3.1-18(b)(1)</p> <p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based on observation and interview, the facility failed to ensure each resident room was provided with full privacy for 1 resident room on the East Unit.</p> <p>Finding includes:</p> <p>On 2/1/16 at 10:13 a.m., Room 109 was observed with 3 beds and a mattress on the floor as the fourth bed. There were 4 residents who resided in the room. The beds located by the window were not</p>	F 0460	<p>THENQUARTERLY REVIEWED WITH ALL STAFF THEREAFTER.</p> <p>F 460 Based on observation and interview, the facility failed to ensure each resident room was provided with full privacy for 1 resident room on the East Unit 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Clean privacy curtain was placed in room that separated the closure of the curtain due to sprinkler system pipes. 2. Describe how the facility reviewed all clients in the facility</p>	03/06/2016	

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	<p>equipped to assure full privacy. The pipes from the sprinkler were located over the tracks of the privacy curtains and did not fully surround each of those beds in the room.</p> <p>Interview with the Maintenance Supervisor on 2/4/16 at 9:00 a.m., indicated he would have to put up another privacy curtain in the room due to the pipes from the sprinkler system.</p> <p>3.1-19(1)(6)</p>		<p>that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No other residents affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Maintenance Department will ensure all privacy curtains surround the resident's bed quarterly and as needed when they are removed for cleaning and repair. Maintenance Department will submit requisition for cleaning, repair or replacement of privacy curtains to Administrator.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Administrator will monitor requisitions as they are submitted and order replacements as needed. Administrator will monitor privacy curtains monthly for one month then semi-annually. Q.A. Committee will meet and monitor cleaning of privacy curtains and need for replacements semi-annually.</p> <p>ADDENDUM ALL OTHER RESIDENT'S</p>	

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the resident's environment was clean and in good repair related to urine odors, torn and broken geri recliners and arm chairs, marred and gouged walls and door frames, paint chipped table bases, stained ceiling tiles, dirty ceiling vents, and dirty toilet bars for 2 of 2 wings, and 1 of 1 dining rooms. (The East, West wings and the Main Dining Room)</p> <p>Findings includes:</p> <p>1. On 2/4/16 at 8:30 a.m., the following was observed during Environmental Tour on the East wing:</p> <p>A. In room 109 the over the toilet grab</p>	F 0465	<p>ROOMS HAVE PRIVACYCURTAINS THAT GO ALL THE WAY AROUND THEIR BEDS. THE ROOMS WITH THE FIRE SPRINKLER SYSTEM THAT RUNS OVER THE CURTAINTRACK ADDITIONAL PRIVACY CURTAINS WERE ADDED TO THEIR ROOMS. NO FURTHER MONITORING IS NEEDED FOR THEPRIVACY CURTAINS.</p> <p>F 465 Based on observation, record review, andinterview, the facility failed to ensure the resident's environment was cleanand in good repair related to urine odors, torn and broken geri recliners andarm chairs, marred and gouged walls and door frames, paint chipped table bases,stained ceiling tiles, dirty ceiling vents, and dirty toilet bars for 2 of 2wings, and 1 of 1 dining rooms. (TheEast, West wings and the Main Dining Room)</p> <p>1.Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. A-Toiletgrab bars next to toilet were tightened by maintenance man. Wall behind toilet bolts and floor tile was replaced bymaintenance man. Beds which have paint chips will</p>	03/06/2016

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	<p>bars next to the toilet were loose. The wall behind the toilet was dirty and the plaster and paint were peeling away from the wall. There was a white substance noted on the wall behind the toilet. The floor register in the bathroom was rusty. The floor tile around the toilet was rusted. The bolts on the toilet were rusted. There was a strong and pungent urine odor in the bathroom. All three beds in the room were paint chipped. The room door and bathroom door frames were gouged and marred. There were 4 residents who resided in the room.</p> <p>B. In room 107 the orange vinyl chairs were cracked and had holes in them. There was a strong urine odor in the bathroom. The bathroom and room door frames were gouged and marred and paint chipped. The floor tile in front of the sink was dirty between the cracks and raised in multiple areas. The bathroom sink cabinets were marred and had peeling paint. The floor register in the bathroom was rusted. There was 1 resident who was alert and orientated with no roommate who resided in the room and 2 residents who shared the bathroom.</p> <p>C. In room 103 the call light outside the room door was burned out and did not light up when pressed. There was a</p>		<p>be touched up by maintenance manbut the beds will be entirely painted according to the preventive maintenance program. This is part of our preventivemaintenance program in which the beds are washed outside and painted in theSpring of the year. Then the entire bedis painted. Theroom door, bathroom door and door frames are being stripped of old paint. Q.A.Committee did not agree with door replacement because it was too costly eachdoor would have been over \$600.00 a piece to replace. So it was recommended and agreed upon toremove the paint from all doors and sand doors throughout the facility. Then a wood stain will be selected and doorswill be varnished along with new kick plates installation. New door stoppers, wood facings and doorsweeps have to be purchased. Doorswhich have been cited will start the process: Room 109, 103, 113, 115 then we will continue throughout the building. B & D & E High Back resident chairs will bereupholstered starting with cited chairsin room 107, 113, 115 The one bathroom sinkcabinet will be replaced in room 107. C. Call light bulb wasreplaced for room 103. The toilet barsand handles were cleaned. E. The sink was replaced in room 115. The urine odor andstained floor tile has</p>		

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	<p>brown adhered substance on the toilet bars across the toilet. The white handles were dirty on the toilet bar. There was rust noted on the floor around the toilet and the floor tile was stained. The bathroom and room door frames were marred and gouged. There was 1 resident who resided in the room and 2 residents who shared the bathroom.</p> <p>D. In room 113 the orange vinyl chairs were cracked and had holes in them. The bathroom door frame was gouged and paint chipped. There was 2 residents who resided in the room.</p> <p>E. In room 115 the orange vinyl chairs were cracked and peeling. The bathroom door frame was marred and gouged. There was a 5 inch crack in the sink. There was 1 resident who resided in the room.</p> <p>F. The only ceiling vent located in the hallway had a large accumulation of dust and dirt noted on and in between the grates.</p> <p>2. On 2/4/16 at 8:40 a.m., the following was observed during Environmental Tour in the Main Dining Room:</p> <p>A. There was a stained ceiling tile located by the windows.</p>		<p>been removed and replaced in rooms 103, 105, 109 over 8times in the past 2 years. The residentswho reside in these rooms urinate on the floor constantly in spite ofmaintenance and nursing staff continuously mopping bathrooms. Q.A. Committee hasreviewed this problem and suggested we get quotes from a tile company whichspecializes in healthcare tile installation so that some type of floor seal canbe applied to prevent the urine from penetrating beneath the tile. Vendors have been called and we are waitingfor a scheduled visit for quotes so that the work can begin. All hallway vents werecleaned and filters replaced. Dining Room stainedceiling tile was replaced. Table bases were painted. Feeding table will beevaluated for replacement or repair. Geri-Chairs were alreadyordered prior to survey but they were back ordered and have now been deliveredto the facility and Resident #20 and #19 have received new geri-chairs. Resident #1 chair wascleaned however his specialized wheelchair has to be evaluated for repairand/or replacement by seating company. Social Service will make arrangements for company to assess theresident's chair.</p> <p>1.Describehow the facility reviewed all clients in the facility that could be affected bythe same</p>				

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	<p>B. The bases of 8 tables and the legs on the assisted feeding table were marred and paint chipped.</p> <p>C. The ceiling vent located in the hallway on the West wing had a large accumulation of dust and dirt noted on and in between the grates.</p> <p>3. On 2/1/15 at 10:13 a.m. the following was observed in the main dining room where the residents were sitting. The geri recliner for Resident #20 was torn in multiple places. The back of the chair was ripped with the yellow foam sticking out. The facility placed a white sheet over the hole. The sides of the geri chair were broken and loose. The foot rest of the chair was broken. The resident's shirt was observed hanging out of the bottom of the chair. The geri recliner for Resident #19 was observed torn in multiple places and had holes in the armrests.</p> <p>Interview with the Maintenance Supervisor on 2/4/16 at 9:00 a.m., indicated they have ordered new chairs and they just have not come in yet.</p> <p>4. On 2/2/16 at 7:30 a.m. the following was observed. The wheelchair for Resident #1 was dirty with dried food</p>		<p>deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <ol style="list-style-type: none"> 1. All paint will be removed from all doors and door frames throughout the facility. 2. All tile will be assessed for replacement and repairs. 3. All toilet bolts and bars will be assessed for rust and repaired. 4. All ceiling vents were cleaned 5. All table bases will be painted 6. All beds will be washed and painted according to preventive maintenance schedule. 7. All sink bases in residents rooms were assessed for repairs. 8. All high back chairs will be assessed for repairs 9. All geri-chairs have been replaced. <p>2. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-Service will be held with new Custodial, Housekeeping and Maintenance Staff about above deficiencies. Preventive maintenance log was reviewed. Cleaning logs were reviewed for daily, weekly and</p>		

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	<p>spillage and food debris noted on the sides. There was a gray cushion observed under the resident. The cushion was observed with a large hole in it. There were pieces of yellow foam pulled out of the cushion. The torn area of the cushion was approximately 10 inches by 5 inches.</p> <p>Interview with the Maintenance Supervisor on 2/4/15 at 9:00 a.m., indicated all the above was in need of cleaning and/or repair.</p> <p>Interview with the Director of Nursing on 2/4/16 at 10:00 a.m., indicated the geri chairs had been ordered, but have not arrived yet. She further indicated the facility did not have any other recliners for the residents.</p> <p>3.1-19(f)</p>		<p>monthly duties.</p> <p>Administratormet with the maintenance, custodial and housekeeping departments and evaluatedthe stages in which the repairs will start the renovation process in residentrooms. Allcited areas for repairs will be done throughout the facility.</p> <ol style="list-style-type: none"> 1.Allpaint will be removed from doors and door frames. 2.Allresident high back chairs will be reupholstered. 3.Bathroomrenovated to include sealing wall and floor tile. 4.Paintingof heat radiators in bathroom. 5.Allbeds will be general cleaned and painted as needed. 6.Newbeds will be purchased 1 a quarter as budget permits. 7.Replacementof sink cabinets with free floating cabinet off the floor so that water frommopping will not deteriorate the cabinets. 8.Roofwill be repaired in the Spring which has caused ceiling tile staining. Ceiling will be replaced as needed. 9.Newover bed lighting will be continued to be updated in resident rooms. <p>This is a largerenovation project that will be ongoing and evaluated by the Q.A. Committee.</p> <ol style="list-style-type: none"> 1.Describehow the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be 	

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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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			<p>put into place. Q.A. Committee will meet and review corrections made due to deficiency's indicated by the survey it will then progress to the listed renovation schedule will be ongoing and evaluation of progress will be assessed quarterly with budget and census income.</p> <p>·ADDENDUM ALL AREAS CITED WILL BE REVIEWED BY THE Q.A COMMITTEE Q 6 MONTHS ONGOING. THE DOORS ARE NOT ALL COMPLETED AT THIS TIME BUT THE DOORS CITED FOR ALL OF THE DOORS TO BE COMPLETED IT WILL REQUIRE AN ADDITIONAL 45 DAYS DUE TO THE DOOR FRAME ALSO HAVING TO BE STRIPPED AND RESTAINED AND VARNISHED. NEW WOOD CASINGS AND DOOR STOPPERS HAVE TO BE RESTAINED AND VARNISHED AND INSTALLED. THE RESIDENT ENTRANCE DOORS, BATHROOM DOORS AND CLOSET DOORS ARE BEING STRIPPED, RESTAINED AND VARNISHED. WE HAVE EMPLOYED ONE PERSON DEDICATED TO THE COMPLETION OF THE DOORS. THE CITED BEDS HAVE BEEN PAINTED BUT AN ADDITIONAL 45 DAYS IS NEEDED TO COMPLETE ALL BEDS IN THE FACILITY. THE PROCESS</p>	

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			<p>REQUIRES FOR THE PREVIOUS PAINTTO BE SCRAPED FROM THE METAL, THE BED IS THEN POWER WASHED, TWO COATS OF METALPRIMER IS APPLIED AND ALLOWED TO DRY AND THEN THE PAINT IS APPLIED. DUE TO THE WEATHER THE PROCESS IS TAKINGLONGER BECAUSE IT IS NOT HOT ENOUGH FOR THE PRIMER TO DRY QUICKLY. WE HAVE ONE EMPLOYEEED PERSON DEDICATED TO THECOMPLETION OF THE BEDS.</p> <p>WE HAVE FOUND A PROFESSIONAL TILE PERSON TOLAY THE TILE IN THE CITED BATHROOMS BUT TESTING HAD TO BE PERFORMED TO ENSURENO ASBESTOS WAS IN THE TILE. NO HE CANBEGAN TO SAND THE TILE DOWN SEAL THE CONCRETE THEN APPLY THE TILE AND APPLY THESEALER AND THEN SEVERAL COATS OF WAX WILL BE APPLIED TO PREVENT THE URINE FROMSEAPING INTO THE SEAMS OF THE TILE. THETILE INSTALLATION WILL START ON FRIDAY 3/25/16. WE HAD TRIED A TOTAL OF 5 TILE INSTALLERS BEFORE WE RECEIVED A RESPONSEFROM THE PERSON WHO WILL BE INSTALLING THE TILE. SO WE WILL NEED ADDITIONAL TIME TO HAVE THENEW TILE</p>	

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F 0520 SS=E Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.		INSTALLED. FIVE CHAIRS HAVE BEEN SENT TO BE REUPHOLSTERED AND HAVE NOT BEEN RETURNED YET. AFTER THE 5 ARE COMPLETED INCREMENTS OF 4 WILL BE SENT FOR REUPHOLSTERED. Q.A. WILL USE THE ABOVE LISTED AREAS AS A GUIDE AND MONITOR IT 6 MONTHS WILL REPAIRS APRIL-OCTOBER FOR ITEMS THAT REQUIRE WARM WEATHER TO BE COMPLETED AND DECEMBER-MARCH FOR INSIDE REPAIRS. PREVENTIVE MAINTANENCE LOG WILL BE MONITORED QUARTERLY AND FACILITY TOURS WILL BE DONE QUARTERLY WITH Q.A.		

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	<p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance for loose side rails on residents beds, dementia training for employees, physical restraints, pre-employment criminal background checks, and resident positioning timely through the quality assurance protocol.</p> <p>Findings include:</p> <p>1. Interview with the Director of Nursing (DoN) on 2/05/16 at 9:19 a.m., indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Social Service Designee, Charge Nurse, Dietician, and the Maintenance Supervisor. The Medical Director and the Pharmacy also attend the monthly meeting. The Director of Nursing indicated at that time, that the loose side rails on the residents beds, dementia training, physical restraints, and criminal background checks had not been formally discussed, addressed or identified as being a problem in Quality</p>	F 0520	<p>F 520</p> <p>Based on record review and interview, the facility failed to identify non-compliance for loose side rails on residents beds, dementia training for employees, physical restraints, pre-employment criminal background checks, and resident positioning timely through the quality assurance protocol</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Please refer to plan of correction for the following: F 221 & F279 Positioning & Restraint, F 323 Side Rails, F 9999 Dementia Training, F 225 & F 226 Criminal History Background Checks</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p>	03/06/2016			

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	<p>Assurance. She further indicated there had been no action plan or system put into place to identify the problem of loose side rails, dementia training, physical restraints, and criminal background checks.</p> <p>The last Quality Assurance meeting was on 1/27/16, and at that time the committee had discussed the wound clinic, staff changes, development of the facilities new web, site and the Medicare application.</p> <p>2. The DoN indicated that the October 2015 meeting the committee discussed resident positioning regarding proper geri chairs. At that time she indicated that Resident #20 was not eligible for a deviation to meet criteria to get a new chair. The family member of Resident #10 refused to bring in the residents social security check to assist with the purchase of a new chair for the resident. She indicated that the facility had informed the Ombudsman of the situation. She further indicated that the facility had ordered new geri chairs which had not arrived, and the purchase order was not available to review at that time.</p> <p>Continue interview with the DoN on 2/5/16 at 9:55 a.m., she indicated that</p>		<p>Anaccumulation of past survey concerns will be logged and placed on our Q.A. Committee meetings to be address ongoing updated on cited deficient findings quarterly.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>D.O.N. will develop new format of Q.A. Committee meetings which will consist of an accumulation of past survey concerns so that an update will be continued to be reviewed quarterly for continued compliance.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Q.A. Committee will review past cited survey items of concern and continue to ensure compliance with review of systems in place. The Q.A. Committee will indicate the need for revisions to areas of concern ongoing.</p>		

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F 9999 Bldg. 00	<p>issues are identified and brought to Quality Assurance by the facilities staff, and or department heads when something needs to be addressed.</p> <p>3.1-52(b)(2)</p>	F 9999	<p>F 9999 Based on record review and interview, the facility failed to ensure documentation of dementia training was completed for 1 of 10 employee records reviewed. (CNA #4)</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>The facility has always mailed the criminal background check to the Indiana State Policy for all of our employees.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>No other employees affected.</p> <p>1. Describe the steps or systemic changes the facility has</p>	03/06/2016
	<p>Based on record review and interview, the facility failed to ensure documentation of dementia training was completed for 1 of 10 employee records reviewed. (CNA #4)</p> <p>Findings include:</p> <p>On 2/5/16 at 9:30 a.m., review of the employment file for CNA #4, date of hire 5/28/15, indicated that the dementia training had not been completed.</p> <p>Interview with the Social Service Designee at that time, indicated the dementia training had not been completed for that employee.</p> <p>3.1-14(l)</p>			

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			<p>made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In-Service held on Dementia Training with employee C.N.A. #4. A log book will be set up for all current employees and employees to indicate dementia training completion.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Office manager will be responsible for keeping book updated as new employees are hired and annual review of dementia training. D.O.N. will review all personnel records for dementia training as new employees are hired and semi-annually. Q.A. Committee will review new hire binder and dementia training logs. Q.A. will determine if further monitoring is needed.</p> <p>ADDENDUM DURING THE SURVEY ALL DEMENTIA TRAINING WAS REVIEWED FOR ALL EMPLOYEES AND NO OTHER EMPLOYEES WERE FOUND TO BE DEFICIENT IN THE TRAINING. A NEW FORM HAS BEEN DEVELOPED THAT CLOSELY RESEMBLES OUR SURVEY FORM FOR EMPLOYEES TO ENSURE</p>	

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			THATALL TRAININGS AND PPD TESTING, LICENSURE, ORIENTATION IS COMPLETED THIS MAKESIT EASY TO CHECK FOR COMPLIANCE. THISWILL BE MONITORED FOR ALL NEW HIRES AND ANNUALLY THEREAFTER.		