

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/14/2015
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NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 6, 7, 8, 9, 12, 13 and 14, 2015.</p> <p>Facility number: 001133 Provider number: 155593 AIM number: 200090430</p> <p>Survey team: Marcy Smith, RN-TC Dottie Plummer, RN Diana Zgonc, RN (January 7 and 8, 2015) Suzi Worsham, RN (January 6, 7, and 8, 2015)</p> <p>Census bed type: SNF/NF: 115 Total: 115</p> <p>Census payor type: Medicare: 10 Medicaid: 70 Other: 35 Total: 115</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc (the "Facility") that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 16/17 Programs) To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of stature only</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000279 SS=D	<p>Quality review completed on January 21, 2015; by Kimberly Perigo, RN.</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 interview and record review, the facility failed to develop a comprehensive plan of care for a resident receiving dialysis for 1 of 1 residents reviewed for dialysis care. (Resident #164)</p> <p>Findings include:</p> <p>The clinical record review, completed on 1/13/15 at 12:07 p.m., indicated Resident</p>	F000279	<p>1. Resident#164 care plan was updated to reflect End Stage Renal Disease with the need for hemodialysis and care of his dialysis access site. A physician's order was added for resident #164 to have a pre and post dialysis assessment completed on his dialysis days and to assess his dialysis access site every shift.</p> <p>2. There are no others residents residing in the Medical Center that receives dialysis for</p>	02/02/2015

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	<p>#164 had diagnoses including, but not limited to, end stage renal disease requiring dialysis. Resident #164 was admitted to the facility on 12/20/14, and had a physician's order to go to dialysis 3 times a week.</p> <p>An Admission Minimum Data Set (MDS) assessment completed on 12/27/14, assessed the resident as having received dialysis prior to admission to the facility as well as receiving dialysis while a resident at the facility. The resident was assessed as requiring extensive assistance of 1 staff member for transfers, bed mobility, bathing, and dressing.</p> <p>A review of the written plans of care for Resident #164 lacked a careplan related to the resident having end stage renal disease including the need to receive dialysis and lacked a careplan related to the care of the dialysis access site.</p> <p>During an interview with the Director of Nursing (DON) on 1/13/15 at 2:30 p.m., the DON indicated the staff should be assessing the resident prior to the resident leaving for dialysis and then upon return from dialysis, and should be assessing the dialysis site every shift. The DON provided the policy Dialysis Access Site Assessment and Care dated 9/20/2004, and indicated the policy was the one</p>		<p>End Stage Renal Disease.</p> <p>3.A pre and post assessment was created for electronic charting. Previously, a paper form was used. A physician's order will be placed into the electronic MAR to cue the nurse to complete a pre and postassessment on resident #164 dialysis days. Resident's admitted to the Medical Center with a diagnosis of End StageRenal Disease with dialysis will be reviewed upon admission and physicianorders will be entered into the electronic MAR to assess the dialysis accesssite and to complete a pre and post assessment on dialysis days. A care plan will be added upon admission forEnd Stage Renal Disease with dialysis and care of the dialysis access site. All Licensed Nurses were educated regarding the needs of residentsreceiving dialysis, adding care plans for End Stage Renal Disease residentswith dialysis needs and care of the access site and completion of the pre andpost assessment located in Point Click Care.</p> <p>4.The DON or Designee will audit all new admissions for a diagnosis of End Stage Renal Disease with needs for dialysis and ifpresent, will ensure that the physician's orders are entered for a pre and postassessment, access site care and care plans to address End Stage Renal Disease with dialysis and access</p>		

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F000282 SS=E	<p>currently used by the facility. The policy indicated, "...Procedure... Assess for signs of infection...Do not measure blood pressure or draw blood from the arm with the fistula or graft. The fistula or graft site will be assessed every shift and will be documented on the Treatment Administration Record...."</p> <p>During an interview with the DON on 1/14/15 at 4:30 p.m., the DON indicated the Treatment Administration Record (TAR) for Resident #164 lacked documentation of assessments of the dialysis site.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure plans of care were implemented and followed for 1 of 1 resident receiving dialysis (Resident #164), failed to ensure physician's orders to increase an antidepressant medication were implemented for 1 of 5 residents reviewed for unnecessary medication usage (Resident #55), and failed to</p>	F000282	<p>site care. The DON or Designee will audit residents with End Stage Renal Disease with dialysis needs three times per week for 90 days then one time per week thereafter. The results of the audit will be discussed at the monthly QA meeting.</p> <p>5.Compliance with these changes will be effective on 02/02/2015.</p> <p>I. Resident #164 care plan was updated to reflect End Stage Renal Disease with dialysis and care of his access site. A physician's order was added for resident #164 to have a pre and post dialysis assessment completed and to assess his access site every shift Resident #55 had duloxetine 20mg capsules on hand. The MD</p>	02/02/2015

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	<p>ensure 3 of 3 residents assessed as being at risk of having constipation had bowel movements every 3 days. (Resident #164, Resident #55, and Resident #162)</p> <p>Findings include:</p> <p>1. The clinical record review, completed on 1/13/15 at 12:07 p.m., indicated Resident #164 had diagnoses including, but not limited to, end stage renal disease requiring dialysis. Resident #164 was admitted to the facility on 12/20/14.</p> <p>An Admission Minimum Data Set (MDS) assessment completed on 12/27/14, assessed the resident as having received dialysis prior to admission to the facility as well as receiving dialysis while a resident at the facility. The resident was assessed as requiring extensive assistance of 1 staff member for transfers, bed mobility, bathing, and dressing.</p> <p>The recapitulation of physician's orders for December 2014, and January 2015, indicated the resident had a physician's order to go to dialysis 3 times a week. An order regarding care of the dialysis site was not included in the orders.</p> <p>The nursing progress notes lacked an assessment of the dialysis site on 12/21/14, 12/22/14, and 12/23/14.</p>		<p>was notified and an order was received to administer 60mg (three capsules) daily. The order was written on 01/13/2015. Resident #164 had a bowel movement on 01/13/2015 and continues to be monitored to ensure that he has bowel movements Resident #55 had abowel movement on 01/12/2015 and continues to be monitored to ensure that she has bowel movements. LPN #1 received education regarding the bowel management program. II. Resident #164 is the only resident receiving dialysis Mail order residents were identified. All mail order residents have received their physician's order timely for medications and the medications were initiated timely. Bowel records of all residents were reviewed to ensure that each resident had a bowel movement every 3 days with intervention if no bowel movement record for 3 days. III. A pre and post assessment was created for electronic medical record documentation. Previously, a paper assessment was used. A physician's order will be placed in the electronic MAR to complete apre and post assessment on residents receiving dialysis. Residents admitted to the Medical Center will be reviewed upon admission and admission orders will be entered into the electronic TAR to assess the dialysis access site every shift. A care</p>		

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	<p>A review of the progress notes indicated the dialysis site was assessed on 12/24/14 at 10:41 a.m., then on 12/25/14 at 3:06 a.m., and 12/25/14 at 13:25 (1:25 p.m.).</p> <p>A physician's order was received on 12/26/14, to send the resident to the hospital for evaluation and treatment for dialysis shunt bleeding. The nursing progress notes lacked an assessment of the dialysis shunt on 12/26/14, and lacked documentation of the resident being transferred to the hospital.</p> <p>The nursing progress notes on 12/27/14 at 00:54 (12:54 a.m.), indicated the resident had returned to the facility at 11:57 p.m. (12/26/14), after having been seen in the emergency room at the local hospital for treatment of bleeding from the dialysis shunt. The next assessment of the dialysis shunt was documented on 12/28/14 at 4:36 a.m., 26 hours after the resident returned from the hospital.</p> <p>During an interview with the Director of Nursing (DON) on 1/13/15 at 2:30 p.m., the DON indicated the staff should be assessing the resident prior to the resident leaving for dialysis and then upon return from dialysis. The DON provided the policy Dialysis Access Site Assessment and Care dated 9/20/2004, and indicated</p>		<p>plan will be added upon admission for End Stage Renal Disease and dialysis access site care. All licensed nurses were educated regarding the needs of residents receiving dialysis, adding care plans for End Stage Renal Disease and care of the dialysis access site and completion of the pre and post assessment located in Point Click Care. Mail order residents have a back-up pharmacy designated. The back-up pharmacy will be utilized to complete the initial prescription fill for timely administration of the new medication to the resident while awaiting delivery of the mail order prescriptions. All nurses were educated on mail order residents and using the back-up pharmacy assigned while awaiting delivery of the mail order medication. All nurses were educated regarding the bowel management program. The nightshift nurse will report all residents that have not had a bowel movement in the last three days. The resident will be placed on pertinent charting. The day shift nurse will intervene and the resident will continue to be monitored until they have had a successful bowel movement. IV. The DON or Designee will audit all new admissions for a diagnosis of End Stage Renal Disease with dialysis. If the resident has a diagnosis of End Stage Renal Disease with dialysis, The DON or Designee will audit</p>	

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	<p>the policy was the one currently used by the facility. The policy indicated, "...Procedure...The fistula or graft site will be assessed every shift and will be documented on the Treatment Administration Record..."</p> <p>During an interview with the DON on 1/14/15 at 4:30 p.m., the DON indicated the Treatment Administration Record (TAR) for Resident #164 lacked documentation of assessments of the dialysis site.</p> <p>2. The clinical record review, completed on 1/12/14 at 2:34 p.m., indicated Resident #55 had diagnoses including, but not limited to, advanced dementia.</p> <p>During a review of the recapitulation of physician's orders for January 2015, the resident was noted to receive duloxetine (Cymbalta a medication used to treat depression) 20 mg (milligrams) twice a day. The start date for the Cymbalta was 9/19/14.</p> <p>A Consultant Pharmacist Recommendation to the Inter-Disciplinary Team (IDT) dated 12/12/14, requested documentation regarding continuing the Cymbalta at 20 mg twice a day or considering a dosage reduction. The IDT response indicated</p>		<p>the chart to ensure that the physician's orders are present for a pre and post assessment, dialysis access site care and care plans for End Stage Renal Disease with dialysis and dialysis access site care. The DON or designee will audit resident's charts that have End Stage Renal Disease with dialysis three times per week for 90 days, then one time per week, thereafter. The DON or Designee will audit all mail order residents' new medication orders to ensure timely initiation of medication 5 days per week for 90 days, then one time per week, thereafter. The DON or Designee will audit all resident's bowel movements and ensure proper administration of the bowel management program 5 times per week for 90 days, then three times per week for 90 days, then weekly thereafter. The results of the of the audits for End Stage Renal Disease with dialysis, mail order residents and bowel movement program will be discussed at the monthly QA meeting. V. Compliance with these changes will be effective on 02/02/2015.</p>		

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	<p>the team requested an increase in the Cymbalta related to crying episodes. An order dated 12/30/14, indicated the Cymbalta was increased to 30 mg twice a day. A review of the Medication Administration Record (MAR) indicated the resident received Cymbalta 20 mg twice a day for 14 days after the order was received to increase the dosage.</p> <p>During an interview with the Director of Nursing (DON) on 1/12/15 at 3:50 p.m., the DON indicated the dose of Cymbalta was supposed to be increased related to a pharmacy recommendation and IDT Meeting . The DON indicated the IDT met monthly to review behaviors, pharmacy recommendations regarding psychotropic medications, and then would forward the recommendations to the physician or nurse practitioner for further orders. The DON indicated a pharmacy recommendation was received in December 2014, regarding a dosage reduction for Cymbalta. The IDT made a recommendation to the Nurse Practitioner (NP) to increase the dosage of Cymbalta due to an increase in crying the resident had been experiencing. On 12/30/14, the NP wrote an order to increase the Cymbalta to 30 mg twice a day and to have a psychiatric consult for the resident. A review of the Medication Administration Record (MAR) on</p>			

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	<p>1/12/15 indicated the dosage of Cymbalta had not been increased as ordered.</p> <p>During an interview with the DON on 1/12/15 at 4:35 p.m., the DON indicated the dosage had not been increased because the resident received the medication via mail order and the medication had been requested but not received by the facility. The DON provided a copy of a prescription written for the resident on 1/5/15, to increase the Cymbalta to 30 mg twice a day. The DON indicated the increased dose had not been implemented yet due to not receiving the medication from the mail order company. The DON also indicated the increased dosage was not written into the clinical record of the resident nor was an order received to continue the 20 mg twice a day dosage until the arrival of the 30 mg capsules.</p> <p>3. a. The clinical record review, completed on 1/13/15 at 12:07 p.m., indicated Resident #164 had diagnoses including, but not limited to, end stage renal disease requiring dialysis.</p> <p>A plan of care dated 1/4/15, indicated Resident #164 was at risk for constipation related to the use of pain medications, decreased mobility, diuretic use (a medication used to treat fluid</p>						

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	<p>retention), and use of psychotropic medications. Interventions included, but were not limited to, administer bowel medications as ordered, monitor bowel patterns, and notify nurse if no bowel movement by the 3rd day.</p> <p>A review of the recapitulation of physician's orders from 12/20/14 - 1/14/15, lacked an order for a bowel medication.</p> <p>A review of the bowel diary for Resident #164 for dates 12/30/14 through 1/14/15, indicated the resident had a bowel movement on 12/31/14. The resident was in the hospital on 12/31/14. The next bowel movement documented for the resident was 3 days later on 1/3/15, then 5 days later on 1/8/15, and 5 days later on 1/13/15.</p> <p>A review of the progress notes lacked documentation of interventions and or physician notifications for the lack of bowel movements.</p> <p>During an interview with the Director of Nursing (DON) on 1/14/15 at 2:15 p.m., the DON indicated the resident was reported as having bowel movements on a regular basis and the staff had not documented them.</p>			

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	<p>b. The clinical record review, completed on 1/12/14 at 2:34 p.m., indicated Resident #55 had diagnoses including, but not limited to, advanced dementia.</p> <p>A plan of care dated 5/19/14, indicated the resident was at risk of developing constipation due to decreased mobility, use of diuretic (a medication used for fluid retention), and the use of psychotropic medications. Interventions included, but were not limited to, monitor bowel movements and notify the nurse if no bowel movement in 3 days.</p> <p>A review of the recapitulation of physician's orders for January 2015, indicated the resident received Senna Laxative 8.6 mg (milligrams) 2 tablets at bedtime for constipation and Healthylax powder 17 gm (grams) once a day for constipation. The resident also had an order for Milk of Magnesia (MOM a laxative) 30 ml (milliliters) every 24 hours as needed for constipation.</p> <p>A review of the bowel diary for December 2014, indicated the resident had 5 days between 12/15/14 and 12/19/14, without having a bowel movement. A review of the Medication Administration Record (MAR) for that time frame lacked documentation of the administration of any as needed</p>			

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	<p>medication for the lack of bowel movements. A review of the progress notes for the same time frame lacked documentation of an assessment and interventions to promote a bowel movement.</p> <p>The MAR for December 2014, indicated the resident received MOM on 12/23/14 and again on 12/25/14. The bowel diary indicated no bowel movement for the resident for 4 days from 12/21/14 through 12/25/14. A review of the progress notes for the same time frame lacked documentation of assessment and interventions to promote a bowel movement.</p> <p>The MAR for January 2015, indicated the resident received MOM on 1/9/15 due to lack of a bowel movement. The bowel diary indicated no bowel movement for the resident from 1/6/15 through 1/12/15. A review of the progress notes for the same time frame lacked documentation of an assessment and interventions to promote a bowel movement.</p> <p>During an interview with Licensed Practical Nurse (LPN) #1 on 1/13/15 at 3:00 p.m., LPN #1 indicated the night shift prepares a list of residents who have not had a bowel movement for 3 days and then the day shift staff reviews the list</p>			

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	<p>and then decides which intervention to use. LPN #1 indicated that sometimes the staff forgets to document when the resident had a bowel movement so the nurse has to ask the staff before the medications are administered to the resident. LPN #1 indicated MOM had been administered to the resident on 1/9/15, as indicated for the lack of a bowel movement and then again on 1/10/15, as the resident still did not have a bowel movement. LPN #1 indicated the second dose on 1/10/15, was not documented on the MAR.</p> <p>A review of the MAR for January 2015, indicated the resident received MOM on 1/9/15. A review of the progress notes for 1/6/15 through 1/12/15, lacked an assessment and documentation of interventions to promote a bowel movement.</p> <p>c. The clinical record of Resident #162 was reviewed on 1/13/15 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, dementia, muscle weakness and difficulty walking.</p> <p>Resident #162 was admitted to the facility 12/24/14.</p> <p>A care plan for the resident, not initiated until 1/2/15, indicated he was at risk for constipation and would have a bowel</p>			

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	<p>movement every 2 - 3 days.</p> <p>Interventions included, "Monitor bowel patterns and notify nurse if no bowel movement by 3rd day...Administer bowel medications as ordered..."</p> <p>Review of a Bowel Diary for Resident #162 indicated he did not have a bowel movement for 8 days, 12/26/15 - 1/3/15.</p> <p>Physician's orders, dated 12/24/14, indicated Resident #162 could receive Milk of Magnesia or MiraLax as needed. Both of these medications are laxatives used to treat constipation.</p> <p>Medication Administration Records for December 2014, and January 2015, indicated Resident #162 did not receive any medication for constipation until 1/4/15, 9 days since his last bowel movement.</p> <p>On 1/14/15 at 2:15 p.m., the Memory Care Coordinator indicated she was unable to find any interventions performed between 12/27/14 and 1/3/15, to relieve Resident #162's lack of bowel movements.</p> <p>On 1/13/15 at 2:30 p.m., the Director of Nursing provided a policy dated 6/5/14, titled, "Bowel Elimination Management," and indicated it was the policy currently</p>			

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F000309 SS=D	<p>used by the facility. The policy indicated, "The licensed nurse...will review each resident's bowel movement record...and make a list of those residents who have had no BM [bowel movement] for 3 days...The nurse will perform a bowel assessment for the residents on the list...Upon completion of bowel assessment, the nurse will give the resident 8 ounces of prune juice, or may give a laxative if the physician has ordered such for prn [as needed] use. Documentation of assessment and intervention at this stage will be in the progress notes of resident's electronic record...Each resident on the list will receive treatment and will be placed on 'pertinent' monitoring until they have a bowel movement..."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to provide the necessary care and services for a resident receiving dialysis to ensure the access site for</p>	F000309	1. Resident#164 care plan was updated to reflect End Stage Renal Disease with the need for hemodialysis and care of his dialysis access site. A	02/02/2015			

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	<p>dialysis was patent and free of signs and symptoms of bleeding or infection for 1 of 1 residents reviewed for dialysis care. (Resident #164)</p> <p>Findings include:</p> <p>The clinical record review, completed on 1/13/15 at 12:07 p.m., indicated Resident #164 had diagnoses including, but not limited to, end stage renal (kidney) disease requiring dialysis. (Dialysis becomes necessary when the kidneys have lost the ability to function.) Resident #164 was admitted to the facility on 12/20/14.</p> <p>An Admission Minimum Data Set (MDS) assessment completed on 12/27/14, assessed the resident as having received dialysis prior to admission to the facility as well as receiving dialysis while a resident at the facility. The resident was assessed as requiring extensive assistance of 1 staff member for transfers, bed mobility, bathing, and dressing.</p> <p>A review of the recapitulation of physician's orders for December 2014, and January 2015, indicated the resident was to go to dialysis 3 times per week. An order regarding the care of the dialysis site was not included in the orders.</p>		<p>physician's order was added for resident #164 to have a pre and post dialysis assessment completed on his dialysis days and to assess his dialysis access site every shift. 2. There is no other resident residing in the Medical Center that receives dialysis for End Stage Renal Disease. 3. A pre and post assessment was created for electronic charting. Previously, a paper form was used. A physician's order will be placed into the electronic MAR to cue the nurse to complete a pre and post assessment on resident #164 dialysis days. Resident's admitted to the Medical Center with a diagnosis of End Stage Renal Disease with dialysis will be reviewed upon admission and physician orders will be entered into the electronic MAR to assess the dialysis access site and to complete a pre and post assessment on dialysis days. A care plan will be added upon admission for End Stage Renal Disease with dialysis and care of the dialysis access site. All Licensed Nurses were educated regarding the needs of residents receiving dialysis, adding care plans for End Stage Renal Disease residents with dialysis needs and care of the access site and completion of the pre and post assessment located in Point Click Care. 4. The DON or Designee will audit all new admissions for a diagnosis of End</p>		

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	<p>A review of the written plans of care for Resident #164 lacked a careplan related to the need to receive dialysis nor the care of the dialysis site.</p> <p>The nursing progress notes lacked an assessment of the dialysis site on 12/21/14, 12/22/14, and 12/23/14.</p> <p>A review of the progress notes indicated the dialysis site was assessed on 12/24/14 at 10:41 a.m., then on 12/25/14 at 3:06 a.m., and 12/25/14 at 13:25 (1:25 p.m.).</p> <p>A physician's order was received on 12/26/14, to send the resident to the hospital for evaluation and treatment for dialysis shunt bleeding. The nursing progress notes lacked an assessment of the dialysis shunt on 12/26/14, and lacked documentation of the resident being transferred to the hospital.</p> <p>The nursing progress notes on 12/27/14 at 00:54 (12:54 a.m.), indicated the resident had returned to the facility at 11:57 PM (12/26/14) after having been seen in the emergency room at the local hospital for treatment of bleeding from the dialysis shunt. The next assessment of the dialysis shunt was documented on 12/28/14 at 4:36 a.m., 26 hours after the resident returned from the hospital.</p>		<p>Stage Renal Disease with needs for dialysis and if present, will ensure that the physician's orders are entered for a pre and post assessment, access site care and care plans to address End Stage Renal Disease with dialysis and access site care. The DON or Designee will audit residents with End Stage Renal Disease with dialysis needs three times per week for 90 days then one time per week, thereafter. The results of the audit will be discussed at the monthly QA meeting. 5. Compliance with these changes will be effective on 02/02/2015.</p>	

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F000371 SS=F	<p>During an interview with the Director of Nursing (DON) on 1/13/15 at 2:30 p.m., the DON indicated the staff should be assessing the resident prior to the resident leaving for dialysis and then upon return from dialysis. The DON provided the policy Dialysis Access Site Assessment and Care dated 9/20/2004, and indicated the policy was the one currently used by the facility. The policy indicated, "...Procedure...The fistula or graft site will be assessed every shift and will be documented on the Treatment Administration Record...."</p> <p>During an interview with the DON on 1/14/15 at 4:30 p.m., the DON indicated the Treatment Administration Record (TAR) for Resident #164 lacked documentation of assessments of the dialysis site.</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and</p>	F000371	It is the intent of this facility to	02/02/2015

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	<p>interview, the facility failed to ensure the water temperature of the dishwasher was hot enough to properly sanitize dishware and the faucets in handwashing sinks provided water warm enough to properly sanitize hands for 2 of 2 kitchen observations. This had the potential to affect all 115 residents residing at the facility.</p> <p>Findings include:</p> <p>1. During a tour of the kitchen with the Dining Services General Manager (DSGM) and Food Service General Manager on 1/7/15 at 11:40 a.m., the DSGM indicated the facility used hot water to sanitize their dishes. Dishware, glassware and silverware needed to reach a temperature of 160 degrees F. (Fahrenheit) in order to be properly sanitized. In order for the dishware to reach a temperature of 160 degrees F., the final rinse water temperature needed to reach 180 degrees F. The dishwasher was observed to have manufacturer's instructions on the front of the machine which indicated the wash temperature should reach 150 degrees F., the rinse temperature should reach 160 degrees F. and the final rinse temperature should reach 180 degrees F. When the dishwasher was put through a cycle at that time, the gauges indicated the wash</p>		<p>maintain watertemperature of the dishwasher at 150 degrees F° for wash, 160 degrees F° forrinse and 180 degrees F° for final rinse to properly sanitize dishware. It is the intent of this facility to maintain watertemperatures at hand washing sinks in the kitchen at 100 – 120 degrees F °within one minute of turning on faucet to properly sanitize hands.</p> <p>1.When the Food Service General Manager was madeaware of low water temperatures on the dishwasher, disposable dishware wasprovided for all meals services, until proper temperatures were achieved on thedishwasher. Vanco calibrated the dishwasher to achieve proper temperatures. Thefinal sprayer copper tube was replaced and the pop off valve was replaced.These interventions maintained wash temperatures at 150 degrees F° for wash,160 degrees F° for rinse and 180 degrees F° for final rinse on the dishwasher.Vanco recommended the facility replace the heat exchanger to the dishwasher.This item was installed as well. A circulating pump was installed to thehand washing sink to ensure water temperatures reach 100- 120 degrees F° withinone minute.</p> <p>2.All residents have the potential to be affected.</p> <p>3.Food Service General Manager/Administrator willin service dietary staff on proper water temperature of the</p>				

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	<p>temperature was 136 degrees F., the rinse temperature was 140 degrees F., and the final rinse temperature was 118 degrees F.</p> <p>The DSGM indicated, in addition to reading the temperature gauges on the outside of the machine, they also placed a test strip on a piece of dishware to indicate the final rinse temperature had reached 180 degrees. Instructions on the test strip read, "When indicator turns black stated temperature [160 degrees F.] [of dishware] has been achieved." The final rinse temperature had to be 180 degrees F. in order for the dishware to reach a temperature of 160 degrees F. A test strip placed on a piece of dishware and put through the dishwashing cycle at that time did not change color at all. The DSGM provided test strips from the previous 7 days, which appeared to have turned a grayish color. He indicated they should have all turned black if the final rise temperature had reached 180 degrees F., and he was going to call the representative from the company the facility contracted with for dishware cleaning/sanitizing to come and figure out what the problem was.</p> <p>During an observation with the DSGM and the representative and a repair technician on 1/7/15 at 4:10 p.m., the</p>		<p>dishwasher; 150degrees F° for wash, 160 degrees F° forrinse and 180 degrees F° for final rinse. Dietary staff will bein-serviced on obtaining watertemperatures from the dishwasher and recording water temperatures each timedishwasher is used. Dietary staff will be in-serviced to notify supervisor ifwater temperatures fall below proper temperatures to sanitize. The hand washing sinks will be monitored toensure water temperatures are between 100-120 degrees F°</p> <p>4. Dietary Supervisor /Designee will reportdishwasher temperatures daily in morning meeting for 7 days and weeklythereafter for thirty days. Food Service General Manager will report to theQuality Assurance committee at each monthly meeting for the next quarter theresults of the dishwater temperatures. The hand washing sinks water temperatureswill be monitored by Food Service General Manager/Designee every day for 7 daysand weekly thereafter for thirty days. Food Service General Manager will report tothe Quality Assurance committee at each monthly meeting for the next quarterthe results of water temperature in hand washing sinks.</p> <p>5. Date of Completion: 02/02/2015</p>		

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	<p>dishwasher was tested and a final rinse temperature of 180 degrees F. could not be reached.</p> <p>The DSGM indicated he was unaware the dishwasher was not reaching it's 180 degrees F. sanitizing temperature, and he counted on his supervisors to inform him of any problems. He indicated the kitchen would be serving all food and drink on plastic/paper ware until the dishwasher was fixed.</p> <p>2. During this same tour on 1/7/15 at 11:40 a.m., 2 handwashing sinks were observed. Handwashing sink #1 had instructions posted above it, "Proper Hand-washing wet your hands with hot running water at least 100 degrees F [Fahrenheit]...." The hot water faucet was turned on and allowed to run for 3 minutes, at which time the temperature of the water tested at 67.3 degrees F. Handwashing sink #2's hot water faucet was turned on and reached 102.6 degrees F. after running for 90 seconds.</p> <p>On 1/13/15 at 9:45 a.m., during an observation with the DSGM (Dining Services General Manager), the hot water faucet in handwashing sink #1 had only reached 88 degrees F. after running for 2 minutes. The hot water faucet in handwashing sink #2 reached 100</p>			

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	<p>degrees F. after running for 90 seconds.</p> <p>On 1/12/15 at 10:00 a.m., the Director of Nursing provided a policy dated 3/2005, titled, "Handwashing," and indicated it was the policy currently used by the facility. The policy indicated, "All employees associated with the handling of food shall wash hands...Use sinks designated for handwashing...Hot water should reach 100 [degrees] F. within 1 minute..."</p> <p>On 1/9/15 at 9:50 a.m., the Director of Nursing indicated all residents received food and/or fluids served from the facility kitchen.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>						