

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155338	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PRESTWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123
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F000000	<p>This visit was for a Recertification and State Licensure survey. This visit included investigation of complaint #'s IN00144667, IN00144643, IN00146660, IN00147389.</p> <p>This visit was in conjunction with investigation of complaint #IN00148102.</p> <p>Complaint #IN00144667-Unsubstantiated due to lack of evidence Complaint #IN00144643-Substantiated. Federal deficiency related to the allegations is cited at F-282. Complaint #IN00146660-Unsubstantiated due to lack of evidence. Complaint #IN00147389-Unsubstantiated due to lack of evidence Complaint #IN00148102-Substantiated. Federal deficiency related to the allegations is cited at F-157</p> <p>Survey Dates: April 28, 29, 30, May 1 and 2, 2014</p> <p>Facility number: 000231 Provider number: 155338 AIM number: 100267900</p>	F000000	<p>The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</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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F000157 SS=D	<p>Survey Team: Mary Weyls RN TC Laura Brashear RN Lora Brettnacher RN Megan Burgess RN Kewanna Gordon RN Connie Landman RN [April 30 and May 1 and 2, 2014]</p> <p>Census Bed Type: SNF: 7 SNF/NF: 80 Total: 87</p> <p>Census Payor Type: Medicare: 7 Medicaid: 65 Other: 15 Total: 87</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 5/7/14 by Brenda Marshall, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's</p>						

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	<p>physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician when a resident's respiratory status deteriorated for 1 of 3 residents reviewed for hospitalization (Resident #149).</p> <p>Findings include:</p> <p>Resident #149's record was reviewed on</p>	F000157	<p><b>F157 Notification of Changes</b></p> <p>It is the practice of this facility to comply with F157 Notification of changes (injury/decline/room)</p> <p><u><b>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></u></p>	06/01/2014

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	<p>5/2/14 at 2:21 P.M. Resident #149 had diagnoses which included, but were not limited to, anxiety, chronic airway obstruction, weakness, pneumonia, and status post tracheotomy. Resident #149 was admitted to the facility for therapy services to increase his strength with a discharge plan for home when his goals were met.</p> <p>A current care plan indicated Resident #149 indicated an infection of his reparatory tract and was at risk for respiratory impairment related to a lobectomy and pneumonia. The plan indicated Resident #149 had a goal of no acute respiratory distress. Interventions included oxygen saturation would be obtained and abnormal values would be reported to the physician, and oxygen would be administered per the physician's orders.</p> <p>A nurses note dated 12/25/13 at 1:44 p.m., indicated, Resident #149 complained of pain and nausea that A.M., he refused stoma care, and his oxygen saturation was 90 percent on 12 liters of oxygen. The record lacked documentation the physician was notified of the care refusal or oxygen saturation not above 90 percent.</p> <p>An untimed physician's admission order</p>		<p>Resident #149 no longer resides at this facility.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility with physician orders for oxygen with parameters identified have the potential to be affected by this alleged finding.</p> <p>A thirty day look back, utilizing an audit tool, for these targeted residents was completed to ensure that any necessary notifications were made to physician/family. Going forward residents who are found to have an oxygen saturation level outside of the ordered oxygen parameters, will have notification made to physician /family.</p> <p>Director of Care Deliver RN (DCD/designee) will monitor, utilizing an audit tool, these residents seven days a week to ensure appropriate notification relates to oxygen levels has been done. Non-compliance will be addressed as discovered.</p> <p>This monitoring will continue until zero negative findings are achieved for four consecutive weeks. Afterwards, random monitoring will occur weekly</p>	

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	<p>dated 11/27/13, indicated Resident #149 was a full code.</p> <p>A physician's order dated 12/4/2013 at 6:20 P.M., indicated, Resident #149's oxygen was to be titrated to maintain his oxygen saturation greater than 90 percent.</p> <p>The record lacked documentation a physician was notified of Resident #149's oxygen saturation that was not maintained above 90 percent.</p> <p>A nurse's note dated 12/26/2013 at 11:11 A.M., indicated, "...Oxygen 84 percent on 12 liters...Resident vomiting green fluid and screaming out, demanding to go to the hospital. PRN (as needed) zofran and clanasepam [sic] given prior to this. MD and family notified. Resident offered KUB (X-ray) and labs to keep here and treat. Resident refused screaming out to go to hospital NOW."</p> <p>An acute transfer record dated 12/26/13 at 11:23 A.M., indicated, Resident #149's vitals were: blood pressure 183/117, pulse 112, respirations 22, and his oxygen saturation was 84 percent on oxygen "via nasal cannula," he was vomiting "green liquid," lung sounds were "crackles," and was sent to the hospital.</p>		<p>ongoing.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Licensed nurses will be educated on notification of resident change of condition to the physician/family. Educational content will address notification based on <i>Interact</i> Change of Condition criteria with emphasis on notifying physician/family when oxygen levels fall outside the ordered parameters.</p> <p>Licensed nurses who fail to comply with expectation of notification will be educated and/or progressively disciplined as indicated.</p> <p><b><u>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 in place?</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review</p>				

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F000164 SS=D	<p>A nurse's note dated 12/26/13 at 5:13 P.M., indicated the facility contacted the hospital and was informed Resident #149 was admitted to the hospital with a diagnoses of pneumonia.</p> <p>During an interview on 5/2/2014 at 3:29 P.M., the DON indicated she could not find documentation of care, assessments, or physician notification when Resident #149 had a documented decline in his respiratory status and oxygen saturations below the physician's ordered level.</p> <p>An undated facility policy titled "Change in Condition: When to report to the MD/NP/PA" indicated, "Immediate Notification Any symptom, sign or apparent discomfort that is: ...A Marked Change (i.e. more severe) in relation to usual symptoms and signs..."</p> <p>This Federal tag relates to Complaint #IN00148102. 3.1-5(a)(2)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone</p>		<p>for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>- <b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p>				

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	<p>communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal privacy during care for 2 of 4 random observations of care. (Resident #39)</p> <p>Findings include:</p> <p>1. On 4/30/14 at 3:00 p.m., LPN #15 was observed to administer a medication to Resident #39 through a gastrostomy tube (g-tube). The resident was in bed and the roommate was seated in a wheelchair in between the two beds. The LPN did not pull the privacy curtain between the two roommates or around the foot of the bed. The resident's top was</p>	F000164	<p><b>F164 Personal Privacy</b></p> <p>It is the practice of this facility to comply with F164 Personal Privacy</p> <p><b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>Resident #39 and the roommate are now receiving personal care in a private setting with privacy curtains pulled between them.</p> <p><b><u>How other residents having the potential to be affected by the</u></b></p>	06/01/2014

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	<p>pulled up to have access to the g-tube and administer the medication.</p> <p>2. On 5/1/14 at 11:55 a.m., LPN #3 and CNA #2 were observed to provide incontinence care to Resident #39. The resident's roommate was seated in a wheelchair in between the residents' beds. The privacy curtain was pulled to the end of Resident #39's bed but not around the end or side of the bed that would have been within view of the exit door if opened.</p> <p>A facility policy titled "AM CARE," dated 12/2009, provided by the DON on 5/2/14 at 10:18 a.m., included, but was not limited to, " 4. Introduce self, explain procedure and provide privacy. " The DON indicated this information is included in training of Resident Rights, and would apply to all types of care.</p> <p>3.1-3(p)(2) 3.1-3(p)(4)</p>		<p><b><u>same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>DCD/ designee will round every shift for three weeks to ensure that each resident receives personal care delivered in a private environment. Any staff member found to be in non-compliance with these resident rights expectation will be addressed immediately. This monitoring, utilizing an audit tool will continue until zero negative findings are achieved for four consecutive weeks. Afterwards, random monitoring will occur weekly ongoing.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Licensed Nurses and Certified Nursing Assistants will be educated on Resident Rights with emphasis on privacy during personal care.</p> <p>Nursing staff who fail to comply with expectation of privacy during personal will be educated and/or progressively disciplined as indicated.</p>	

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F000241 SS=D	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, interview, and record review the facility failed to maintain resident's dignity by standing to assist 7 residents with feeding and/or not serving each resident seated at the same table, before serving another table, during	F000241	<u>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 in place?</u>  - Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.  Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.  - <u>By what date the systemic changes will be completed?</u>  - June 1, 2014  F241  It is the practice of this facility to comply with F241 Dignity and Respect of Individuality  <u>What corrective actions(s) will</u>	06/01/2014	

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	<p>2 of 2 dining observations (Resident #42, #138, #76, #12, #76, #92, #173)</p> <p>Findings include:</p> <p>1. On 5/2/2014 from 8:25 a.m. to 8:40 a.m., during the breakfast dining observation in the South Dining Room, Resident #42, Resident #138, Resident #76 and Resident #12 were observed sitting with their breakfast trays in front of them at the dining table. RN #7 stood next to the table and offered cues and bites of food to all residents. RN #7 stood while she offered Resident #12 a spoonful of eggs. The RN offered Resident #76 a bite of food as she stood over her.</p> <p>During an interview on 5/2/14 at 8:40 a.m., RN #7 indicated she provided full feeding assistance for Resident #92 and Resident #138, and provided Resident #76 and Resident #12 with minimal feeding assistance.</p>		<p><b><u>be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>- Residents #42, 38,76,12,76, 92,173 are receiving assistance or being fed by staff who are seated and at eye level to the resident.</p> <p>Residents seated at the same table for a meal are served their meal in sequence.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility require assistance with feeding or receive their meal in the dining room have the potential to be affected by this alleged finding.</p> <p>DCD/designee will be present each meal for seven days to ensure that residents requiring assistance with feeding are assisted by a seated staff person and residents seated at the same table will receive their meals in sequence.</p> <p>Monitoring, utilizing an audit tool, of these dining practices will continue one meal a day until three consecutive weeks of 100% compliance is achieved.</p>				

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			<p>Afterwards, random monitoring will occur weekly ongoing.</p> <p>Any staff member found to be in non-compliance with these resident rights expectation of feeding assistance and tray service will be addressed immediately.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Licensed Nurses and Certified Nursing Assistants will be educated on Resident Rights with emphasis on feeding assistance while seated with the resident, and residents seated at the same table receiving their meals in sequence.</p> <p>Nursing staff found to be in non-compliance with this resident rights expectation of feeding assistance and tray service, will be addressed immediately. Nursing staff who fail to comply with these expectations will be educated and/or progressively disciplined as indicated.</p> <p><b><u>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 in place?</u></b></p> <p>- Results of the monitoring will be</p>		

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents were given choices regarding wake times, bed times, and bath and shower preferences for 2 of 3 residents interviewed for choices (Resident 119 and 53).</p> <p>Findings include:</p>	F000242	<p>reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p><b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p> <p><b>F 242</b></p> <p>It is the practice of this facility to comply with F 242: Self-Determination- Right to make Choices</p> <p><b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p>	06/01/2014

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	<p>1. During an interview on 04/29/2014 09:00 a.m., Resident #119, indicated he did not choose when to get up in the morning. He indicated he was awakened by facility staff every morning. He also indicated he did not have a choice of what time he went to bed at night. He further indicated he did not get to decide how many times a week he bathed, nor whether he took a shower or a tub bath.</p> <p>During an interview on 5/1/14 at 3:31 p.m., the DON (Director of Nursing) indicated, Resident #119 had indicated to the facility on previous occasions that they wake him up to early. DON stated he was suppose to be a later wake up time, but staff had not been doing that.</p> <p>2. During an interview on 05/01/2014 at 1:56 p.m., Resident #53, indicated he did not have a choice regarding his rise time. He indicated he was awakened at 6 a.m., on this particular day and he would have liked to have slept in longer.</p> <p>On 5/02/2014 at 10:09 a.m., Resident #53 was awakened and transferred to his wheel chair. During the transfer Resident #53 asked CNA #10 why he needed to get up. CNA #10 indicated she was getting him up because it was time to get up. The resident was observed with his eyes closed and he groaned. Resident</p>		<p>- Residents #119 and 53 have been re-interviewed regarding choices for morning get up times and evening bed times, as well as, choice of shower or bath. Preferences will be honored. Care plans and CNA task lists have been updated.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>The week of May 12, 2014, residents or their POA were interviewed regarding choices for morning get up times and evening bed times, as well as, choice of shower or bath. Preferences will be honored. Care plans and CNA task lists have been updated to reflect preferences.</p> <p>Quarterly, resident preferences will be revisited at care plan time. Care plans and CNA task lists have been updated to reflect preferences.</p> <p>New residents upon admission will be interviewed about their preference for morning get up times and evening bed times, as well as, choice of shower or bath. Preferences will be honored.</p>		

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	<p>#53 was observed in his wheel chair with his eyes closed. CNA #10 had to call his name to arouse him from sleep to give him further instructions and directives regarding his care.</p> <p>A review of a document entitled, "abaqis/ Complete Resident Interview," dated 2/18/14 and received from the DON on 5/1/14 at 3:31 p.m., indicated Resident #119 made the facility aware of his need for a later wake time and lack of choices regarding bedtime. Resident #119 also indicated he does not choose how many times a week he bathes, or whether he gets a tub bath or a shower. Patient filled out a concern form at that time.</p> <p>A review of an activities of daily living form received from the DON on 5/1/14 at 3:09 p.m., for resident #53, indicated resident was noted as a, "late morning riser."</p> <p>3.1-3(u)(3)</p>		<p>- <b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Licensed Nurses and Certified Nursing Assistants will be educated on Resident Rights with emphasis on preference for morning get up times and evening bed times, as well as, choice of shower or bath.</p> <p>Nursing staff found to be in non-compliance with this resident rights expectation of related to choices of getting up and going to bed, as well as, choice of shower or bath, will be addressed immediately. Nursing staff who fail to comply with these expectations will be educated and/or progressively disciplined as indicated.</p> <p><b><u>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 in place?</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends quarterly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed quarterly by the Administrator/Designee until compliance is achieved.</p>		

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information</p>		<p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations quarterly ongoing.</p> <p>- <b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p>	

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	<p>regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure the dental assessment portion of the Resident Assessment Instrument (RAI) was completed for 1 of 3 residents reviewed in a sample of six residents who met the criteria for dental concerns (Resident #53).</p> <p>Findings include:</p> <p>On 04/29/2014 at 3:35 p.m., during an interview, Resident #53 indicated he needed to see a dentist due to having broken teeth on both the left and right side of his mouth. The resident indicated the broken teeth were uncomfortable for him when he ate. He also indicated he was supposed to have a dental appointment, but it had been canceled several times over the last few months. He indicated he was not aware of a future appointment time to see the dentist. He indicated he had the broken teeth for several months.</p> <p>In an interview on, 5/2/14 at 3:55 p.m., the MDS coordinator indicated she had forgotten to document the dental</p>	F000272	<p><b>F272</b></p> <p>It is the practice of this facility to comply with F272 Comprehensive Assessments</p> <p><b><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>- Resident #53 MDS Section L most recent Comprehensive and Quarterly were reviewed and all questions were responded to correctly and completely.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding. An audit was completed on residents in reference to completion of Section L on their most recent RAI. No incomplete records were found.</p> <p>DCD/designee will review Section L for completed resident</p>	06/01/2014			

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	<p>information in the MDS for Resident #53.</p> <p>The review of the document entitled "MDS 3.0 Nursing Home Quarterly (NQ) Version 1.11.2," provided by the MDS coordinator, on 5/2/14 at 3:55 p.m., for Resident #53, Section L Oral/Dental Status, did not have any information regarding the residents dental status for broken teeth.</p> <p>3.1-31(9)</p>		<p>assessment instruments (RAI) for the prior week. Incomplete records will be referred to the MDS Coordinator for correction and follow through.</p> <p>This monitoring, utilizing an audit tool will continue until four consecutive weeks of zero negative findings are achieved. Afterwards random monthly monitoring will take place.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- MDS and Nursing Management staff was trained from the RAI manual on completion of Section L on any RAI assessment.</p> <p>Failure to comply with these expectations will result in education and/or progressively disciplined as indicated.</p> <p><b><u>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 in place?</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until</p>		

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, interview, and record review the facility failed to provide services in accordance with care plans for proper administration of medications, provision of mouth care, and pain management. (Residents #39, #53, and Resident A)</p> <p>Findings include:</p> <p>1. On 4/30/14 at 3:00 p.m., LPN #15 was observed to administer a medication to Resident #39 through a gastrostomy tube (g-tube). The medication had been prepared prior to the observation. The g-tube was attached to a feeding pump that was off. The Medication Administration Record (MAR)</p>	F000282	<p>compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p><b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p> <p><b>F282</b></p> <p>It is the practice of this facility to comply with F-282: Services by Qualified Persons/Per Care Plan</p> <p><b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>- Resident # 39 is receiving 30 cc water flush before and after medication administration through g-tube.</p> <p>Resident #39 receives Metrocreme 0.75% daily per physician order.</p> <p>Resident A receives Hydrocodone 10/325 every four</p>	06/01/2014

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	<p>documented a bolus feeding was provided at 2:00 p.m. The nurse disconnected the tube, poured water into a crushed medication in a cup, poured the medication slurry into a syringe attached to the g-tube, and repeated the process finishing with a water flush. The tube was not flushed with water prior to medication administration.</p> <p>Resident #39's clinical record was reviewed on 5/2/14 at 10:09 a.m. The April 2014 recapitulation of physician's orders signed by the physician, included, but was not limited to: "Flush tube with 30 ml (milliliters) water before and after meds and 5-10 ml between med administration." The order was dated 2/11/12.</p> <p>A facility policy titled "Enteral Tubes: Medication Administration," dated 2/2012, provided by the DON on 5/2/14 at 10:18 a.m., included but was not limited to, "11. Verify enteral tube placement ...12. Flush tube with a minimum of 30 ml of water..."</p> <p>2. On 5/2/13 at 10:09 a.m., Resident #39's clinical record was reviewed. A physician's order dated 4/14/14 was noted to apply Metrocream (topical cream utilized to treat Rosacea) 0.75% one time daily. The order transcribed on the April 2014 Medication administration record (MAR) was to administer the medication four times a day, and was documented as</p>		<p>hours PRN pain.</p> <p><i>NOTE: Provision of neither mouth care nor Resident #53 is addressed in this finding.</i></p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility with the following have the potential to be affected by this alleged finding:</p> <ol style="list-style-type: none"> <li>Residents receiving medication via g-tube</li> <li>Residents with topical treatment orders</li> <li>Residents who have orders for PRN pain</li> </ol> <p>DCD/designee will monitor, utilizing an audit tool, medication administration via g-tubes for three residents per day for seven days. Monitoring will be five days a week, until three weeks of zero negative findings are achieved. Afterwards random monitoring will occur weekly ongoing.</p> <p>DCD/designee will do thirty day look back, utilizing an audit tool, to ensure each medication order has been accurately transcribed to the MAR. Any discrepancies will be corrected when found and all necessary notifications will be made. Physician orders will be</p>				

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	<p>given. The Nursing Manager for the South Unit was interviewed on 5/2/14 at 1:21 p.m. The Manager clarified the order and indicated it was to be administered one time a day instead of four times a day as listed on the MAR..</p> <p>3. Resident A's clinical record was reviewed on 5/2/14 at 1:34 p.m. A physician's order dated 1/18/14 was noted to give Hydrocodone 10-325 (pain medication) one by mouth every four hours.</p> <p>A form titled "FESA" Formula Coaching," provided by the South Unit Manager on 5/12/14 at 1:34 p.m., included but was not limited to: "Medication error on pt (patient) in Room (room number) x (times) 2 doses on 2/17/14-2/18 NOC (night shift)." Documentation on the investigation of the errors indicated the night shift nurse had given the wrong dose of medication which resulted in the patient given a lower dose of the same medication. The South Unit Manager was interviewed on 5/2/14 at 1:34 p.m. The Manager indicated the resident received a lower dose of hydrocodone 5-325 on the night shifts of 2/17/14 and 2/18/14. The Manager indicated the nurse who had made the errors received counseling and education. The pain assessment for the time period did not reflect an increase in</p>		<p>crosschecked with the MAR within 24 hours of receipt of the order to validate accurate transcription. Any discrepancies will be corrected when found and all necessary notifications will be made. Monitoring will be ongoing.</p> <p>DCD/designee will second check administration of PRN pain medication to validate dose accuracy three times a shift for seven days. This monitoring, utilizing an audit tool, will be once a day for seven days a weeks until three weeks of zero negative findings are achieved. Afterwards random monitoring will occur weekly ongoing. Discrepancies will be corrected when found.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Licensed Nurses will be educated on the following facility guidelines:</p> <ol style="list-style-type: none"> <li>1. Enteral Tubes: Medication Administration</li> <li>2. Orders Management: Transcribing or Noting</li> <li>3. Medication Management "Six Rights Plus One" and Errors.</li> </ol> <p>Nursing staff who fail to comply with these facility guidelines will be educated and/or progressively</p>				

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F000309 SS=E	<p>pain. This Federal tag relates to Complaint IN 001444643. 3.1-35(f)(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. Based on observations, record review, and interview, the facility failed to ensure information was available from dialysis</p>	F000309	<p>disciplined as indicated.</p> <p>- <b><u>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 in place?</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>- <b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p> <p><b>F309</b> It is the practice of this facility to</p>	06/01/2014	

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	<p>for continuity of care, services were provided to address pain management and timely assessments were provided to address a significant change in a resident's physical condition. (Resident #'s 101, 53 and 149)</p> <p>Findings include:</p> <p>1. During review of Resident #101's clinical record on 5/1/14 at 10:20 a.m., a diagnosis was noted of End Stage Renal Disease (ESRD). Progress notes, dated 4/23/14 at 8:14 p.m., indicated the resident went to an outside hemodialysis unit on Monday, Wednesday and Friday. Documentation of Resident #101's dialysis response/post procedure care was not provided to the facility from the outside service provider.</p> <p>RN #13 was interviewed on 5/1/14 at 11:20 p.m. The RN indicated the facility sent information to the dialysis unit, but the facility did not receive information back from the dialysis unit, The RN indicated at times the dialysis unit called if they want the resident placed on an antibiotic "or such, but not frequently."</p> <p>During interview of the DON (Director of Nursing) on 4/23/14 at 11:25 a.m., the DON indicated she requested, "communicating with the facility</p>		<p>comply with F309: Provide care/Services for Highest Well Being</p> <p><b>What corrective action will take place for those residents found to be affected by the deficient practice?</b></p> <p>Resident #101 has post dialysis notes from the dialysis clinic on the three days a week she goes for dialysis.</p> <p>Resident #53 had a Pain Evaluation 5.10.2014. Pain is being managed with routine and PRN pain meds.</p> <p>Regarding the dental concern, Resident #53 was seen by the dentist on 5.15.2014. The dentist recommended he see an oral surgeon for a non-emergent extraction. Oral surgery appointment is pending. Please note, that in January 2014, resident refused this same extraction.</p> <p>Resident #149 no longer resident in this facility.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>Residents who reside in this facility receiving hemodialysis have the potential to be affected</p>				

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	<p>routinely concerning treatment the resident receives at the unit." The DON indicated the dialysis unit had not responded to the request.</p> <p>Review of a facility policy and procedure titled "Guidelines for Hemodialysis Patient Care," dated "2006" and received from the DON on 5/1/14 at 11:15 a.m., indicated, "Center responsibilities include giving the hemodialysis center an up-to-date status report that includes the patient's medication list and last doses, vital signs, treatments, the patient's overall condition and, or events since last dialysis treatment. Following dialysis a complete report of the dialysis session should be expected to accompany the patient back to the center."</p>		<p>by this alleged finding.</p> <p>Resident 101 will be monitored each dialysis day by the ADNS/designee to ensure follow up report is received from the dialysis clinic on the day of the dialysis run. If no report is received on the day of the run, ADNS/designee will contact dialysis clinic manager to request report and problem solve the delay.</p> <p>This practice will be ongoing with residents on hemodialysis with dialysis clinics.</p> <p>Residents who reside in this facility have the potential to be affected by this alleged pain finding.</p> <p>A thirty day look back, utilizing an audit tool, for pain evaluations was completed on these residents. Resident with a pain score of four to seven twice in a seven day period or a score of eight, nine or ten at a single time was reviewed to validate completion of the pain assessment, and the efficacy of the med regimen. Discrepancies will initiate a new pain evaluation and assessment if found.</p> <p>DCD/designee will review, utilizing an audit tool; pain scores daily and will initiate the pain management protocol for</p>		

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			<p>Residents with a pain score of four to seven twice in a seven day period or a score of eight, nine or ten at a single time.</p> <p>This monitoring will continue be ongoing.</p> <p>Residents who reside in this facility receiving ordered oxygen therapy who experience change of condition, i.e. oxygen saturation outside ordered parameters, have the potential to be affected by this alleged finding.</p> <p>DCD/designee will monitor, utilizing an audit tool, residents with oxygen parameters, every shift for seven days for one week to ensure appropriate oxygen levels are maintained within ordered parameters. Residents found to have an oxygen level outside ordered parameters will have complete respiratory assessment and physician/family notifications will occur.</p> <p>Non-compliance will be addressed as discovered. This monitoring will continue until zero negative findings are achieved for three consecutive weeks. Afterwards, random monitoring will occur weekly.</p> <p><b>What measures will be put into place or what systemic</b></p>		

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			<p><b>changes will be made to ensure that the deficient practice does not reoccur?</b></p> <p>Licensed nurses will be educated on the importance of inter-facility communication on dialysis residents between the facility and the dialysis clinic, which will include pre/post dialysis information as defined on documentation tool provided to the clinic. If post dialysis information is not received by the facility, staff will contact the dialysis clinic to request immediate information. ADNS will be informed and communication will be initiated with the dialysis clinic.</p> <p>Licensed nurses and Certified aides will be educated on Pain Management Guidelines with emphasis on dental and generalized pain.</p> <p>Licensed nurses and Certified aides who fail to comply with expectation of their role in Pain Management Protocol will be educated and/or progressively disciplined as indicated.</p> <p>Licensed nurses will be educated on respiratory assessment of resident change of condition and documentation of alleged findings. Educational content will address assessment based on</p>		

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F000322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of		<p><i>Interact</i> Change of Condition criteria with emphasis on assessment and reporting alleged findings to the physician when oxygen levels fall outside the ordered parameters.</p> <p>Licensed nurses who fail to comply with expectation of assessment and documentation will be educated and/or progressively disciplined as indicated.</p> <p><b>How will the corrective actions be monitored to ensure they do not occur again?</b></p> <p>Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p><b>By what date will the changes occur?</b></p> <p>June 1, 2014</p>		

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	<p>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.</p> <p>Based on observation and record review the facility failed to provide services to prevent potential complications of gastrostomy tube use for 1 of 3 observations of providing medication and/or feeding. (Resident #39)</p> <p>Finding includes:</p> <p>On 4/30/14 at 3:00 p.m., LPN #15 was observed to administer a medication to Resident #39 through a gastrostomy tube (g-tube). The medication had been prepared prior to the observation. The g-tube was attached to a feeding pump that was off. The nurse disconnected the tube, poured water into a crushed medication in a cup, poured into a syringe attached to the g-tube, and repeated the process finishing with a water flush. The tube was not flushed with water prior to medication</p>	F000322	<p><b>F322</b></p> <p>It is the practice of this facility to comply with F322 Treatment/Services-Restore Eating Skills</p> <p><u><b>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></u></p> <p>- Resident # 39 is receiving 30 cc water flush before and after med administration through g-tube.</p> <p><u><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></u></p> <p>- Residents who reside in this facility receiving medication via g-tube have the potential to be</p>	06/01/2014
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	<p>administration.</p> <p>Resident #39's clinical record was reviewed on 5/2/14 at 10:09 a.m. The Medication Administration Record (MAR) documented a bolus feeding was provided at 2:00 p.m.</p> <p>The April 2014 recapitulation of physician's orders signed by the physician, included, but was not limited to: "Flush tube with 30 ml (milliliters) water before and after meds and 5-10 ml between med administration." The order was dated 2/11/12.</p> <p>A facility policy titled "Enteral Tubes: Medication Administration," dated 2/2012, provided by the DON on 5/2/14 at 10:18 a.m., included but was not limited to, "11. Verify enteral tube placement ...12. Flush tube with a minimum of 30 ml of water..."</p> <p>3.1-44(a)(2)</p>		<p>affected by this alleged finding.</p> <p>DCD/designee will observe medication administration via g-tubes three residents per day for seven days. Monitoring, utilizing an audit tool, will be done five days a week, until three weeks of zero negative findings are achieved. Afterwards random monitoring will occur weekly ongoing.</p> <p>- <b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Licensed Nurses will be educated on Enteral Tubes: Medication Administration</p> <p>Nursing staff who fail to comply with these facility guidelines will be educated and/or progressively disciplined as indicated.</p> <p><b><u>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 in place?</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by</p>		

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation and interview the facility failed to ensure suction machines would be operable in the event of a power outage for 10 of 10 suction machines in use.</p> <p>B. Based on observation, interview, and record review the facility failed to ensure a safe environment in that 3 of 6 nursing units had water temperatures in excess of 120 degrees Fahrenheit.</p> <p>C. Based on observation, interview, and record review the facility failed to ensure safety for 1 of 3 residents who met the criteria for accidents in that</p>	F000323	<p>the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>- <b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p> <p><b>F 323</b></p> <p>It is the practice of this facility to comply with F 323 Free of Accident Hazards/Supervision/Devices</p> <p><b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>No residents were affected by this alleged finding as it related to suction machines. Suction machines have access to electrical power, even in the event of a power outage.</p>	06/01/2014	

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	<p>manufacturer's directions for mechanical lift sling use was not followed. (Resident #53)</p> <p>Findings include:</p> <p>A. On 4/28/14 during observation of meal service which began at 12:00 p.m., a suction machine was observed in a corner of the South Dining Room. An electrical cord was observed on the machine and an orange extension cord on a shelf underneath the machine.</p> <p>LPN #16 and RN #17 were both assisting in the dining room. The staff were interviewed as to if the suction machine was battery operated and they indicated they didn't think so. The staff thought there would be red outlets that would operate in the event of a power outage. No outlets in the dining room were identified as emergency outlets.</p> <p>No emergency outlets were observed in a seating area/hallway outside of the dining room.</p> <p>On 4/28/14 at 1:00 p.m., RN #19, indicated she worked both units of the facility. The nurse identified the suction machine on the crash cart next to the nurses' station was an electric suction machine. The nurse indicated emergency</p>		<p>No residents were affected by this alleged finding as it related to water temperatures. Water temperatures in the resident environment do not exceed 120 degrees Fahrenheit. The mixing valve was replaced on April 29, 2014.</p> <p>Manufacturer's directions for mechanical lift slings are being followed for Resident #52</p> <p>- <b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding related to suction machines and water temperatures.</p> <p>Extension cords have been checked to ensure proper lengths to reach emergency outlets. Additional emergency outlets were installed on April 29, 2014 in the North and South Dining Rooms. There were adequate emergency outlets to accommodate the remaining eight suction machines.</p> <p>Water temperatures were checked in the remainder of the facility and they were in acceptable parameters.</p> <p>Residents who reside in this</p>	

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	<p>outlets were not available in residents' rooms. One red outlet was observed in the middle of the 100 hall way.</p> <p>On 4/28/14 at 1:45 p.m., CNA #18 was interviewed. The CNA indicated there is one red outlet in the middle of each hall that were for emergency power outage.</p> <p>The DON was interviewed on 4/28/14 at 1:36 p.m. The DON indicated she was not sure if the suction machines in the dining rooms were battery or electrically powered. The DON indicated she would plug into a red plug but couldn't find any.</p> <p>On 4/28/14 at 1:54 p.m. the Maintenance Supervisor (MS) was interviewed. The MS indicated the red and orange outlets are the only ones capable of powering a suction machine when running on generator power. The MS indicated the closet emergency outlets to the dining rooms were in the kitchen and extension cords were located on the carts. After measurements of the cords was done, it was determined the cords were not long enough.</p> <p>On 4/28/14 at 2:00 p.m. the Maintenance Supervisor indicated the cord on the crash carts suction machines were approximately six feet long. The supervisor indicated residents who</p>		<p>facility, utilizing mechanical lifts, have the potential to be affected by the alleged finding regarding mechanical lift slings.</p> <p>DCD/designee will monitor, utilizing an audit tool, daily ongoing to ensure there are no residents up out of bed and left with a mechanical lift sling under the resident.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Nursing staff were educated on the location of the emergency outlets for use with the suction machines in the event of a power outage.</p> <p>Water temperatures are being checked daily, utilizing an audit tool, by the Maintenance Supervisor/Designee on each hall to ensure the proper temps are within acceptable parameters.</p> <p>Nursing staff will be educated related to the Mechanical Lift Policy with emphasis on the removal on the mechanical lift sling after the transfer.</p> <p>Facility staff who fail to comply with these facility guidelines will be educated and/or progressively disciplined as indicated.</p>		

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	<p>required suctioning in their rooms would have to be brought out to the hallways as no generator powered plugs were in residents' rooms with exception of the "new side" of the building (part of the 800 hall.)</p> <p>On 5/2/14 at 11:00 a.m., the DON provided a list of ten residents identified with swallowing difficulties who utilized the dining rooms.</p> <p>On 5/2/14 at 3:05 p.m. the DON indicated five suction machines were in residents' rooms, two in the dining rooms, two on the crash carts, and one in the Activity office.</p> <p>B. On 4/29/14 at 10:17 a.m. Resident #79 was interviewed. The resident's bathroom sink water temperature felt very hot to the touch.</p> <p>On 4/29/14 at 11:45 a.m., the Maintenance Supervisor (MS) was observed to check the water temperature. The sink in Resident #79's bathroom was 127 degrees Fahrenheit (F). The MS used a digital orange thermometer, identified as the one always used. The supervisor indicated he had no idea how to calibrate the device.</p> <p>Other points of use were checked with a</p>		<p><b><u>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 in place?</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p><b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p>				

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	<p>sister facility Administrator who utilized a different thermometer. The following temperatures were found on 4/29/14 at 11:45 a.m.:</p> <p>Room 603-sink-127 degrees F Room 613-sink-122.3 degrees F Room 612-sink-128.3 degrees F 600 hall shower -131.7 degrees F</p> <p>On 4/29/14 at 11:55 a.m. the following temperatures were obtained: Room 710-sink-131.3 700 hall shower-131.5 800 shower-130.1 degrees F</p> <p>The supervisor indicated he checked water temperatures at different points of use daily which resulted in all rooms being checked monthly. The supervisor indicated one heater supplied water to the 100, 200, and 300 halls, one supplied water to the 600, 700, and part of 800 halls. After completion of checking the water temperatures, the MS indicated the valve on the hot water heater supplying water to the 600, 700, and 800 halls was "froze up" at 115 degrees F. The staff member indicated the water in the tank was 140 degrees F but the broken valve was preventing the water from being mixed to supply water at acceptable temperatures.</p>			

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F000329 SS=D	<p>The MS indicated a log of water temperatures was maintained. After 1:00 p.m. water temperature logs were provided no temperatures were recorded in excess of acceptable range.</p> <p>Documentation at the bottom of the "Water Temperature Log," included "Check at least one room on a different wing daily. Check all rooms monthly. Cover Resident room and shower room temperatures.</p> <p>The manufacture's directions for the thermometer identified by the MS as the one always used were provided by the Administrator on 4/30/14 at 9:40 a.m. did not include any guidance on how to maintain calibration.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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</p>			

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	<p>treat a specific condition as diagnosed and 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 ensure residents who had not used anti-psychotic medications were not given anti-psychotic medications without an appropriate indication for use for 1 of 5 residents reviewed for unnecessary medications (Residents #67).</p> <p>Findings include:</p> <p>Resident #67's record was reviewed on 4/30/2014 at 3:08 P.M. Resident #67 had diagnoses which included, but were not limited to, dementia, hypothyroidism, kidney disease, constipation, coronary artery disease, and hypertension.</p> <p>An untimed physician's order dated 3/21/14, indicated Risperidone (anti-psychotic medication) 0.5 mg (milligrams) tablet was prescribed once daily at 5 P.M. for Resident #67 for dementia with behavioral symptoms.</p> <p>The record lacked documentation of a diagnoses or appropriate indication for the use of an anti-psychotic medication.</p>	F000329	<p><b>F 329</b></p> <p>It is the practice of this facility to comply with F 329 Drug Regimen is Free from Unnecessary Drug</p> <p><b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>- Resident #67 has been reevaluated for appropriate diagnosis which identifies the indicators for any antipsychotic medications being used.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility receiving antipsychotic medications have the potential to be affected by the alleged finding and have been identified through chart reviews.</p> <p>Social Services will validate, utilizing an audit tool, that residents receiving ordered</p>	06/01/2014

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	<p>During an interview on 4/30/2014 at 3:37 P.M., the Director of Nursing (DON) was queried regarding Resident #67's anti-psychotic medication use. The DON was asked to provide documentation of indication for the use of Risperidone.</p> <p>During an interview on 5/1/2014 at 1:51 P.M., Certified Nursing Assistant (CNA) #4 indicated she had been assigned to Resident #67's hall since January 2014. She indicated Resident #67 was hard of hearing and did not wear hearing aids. CNA #4 stated, "He is cooperated with care. He gets agitated when something doesn ' t work like his ear phones. He will come to the door to tell me. He has never hit at me. I've never seen him act like he was going to hit anyone. He is easily redirected. When he wants it, he wants it now. I know him so I don't have a problem with him."</p> <p>During an interview on 5/1/2014 at 2:07 P.M., The DON indicated she looked through Resident #67's "entire chart." She indicated Resident #67 had been seen by psychiatric services and they recommended putting him on "Depakote" (mood stabilizer). The DON indicated she "argued" for months with the Nurse Practitioner (NP) about starting Resident</p>		<p>antipsychotic medications or residents who receive a new order for an antipsychotic medication, has an appropriate diagnosis. Discrepancies will be discussed with the physician/prescriber to review the indicators and documentation to substantiate the need for the antipsychotic with an appropriate diagnosis.</p> <p>This validation by the Social Services will continue ongoing.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <ul style="list-style-type: none"> <li>- Social Service and nursing staff will be educated on appropriate indication for use of Antipsychotic Medication and associated documentation requirements.</li> <li>- Social Service and nursing staff who fail to comply with these facility guidelines will be educated and/or progressively disciplined as indicated.</li> </ul> <p><b><u>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 in place?</u></b></p> <p>Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS.</p>				

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	<p>#67 on Depakote for behaviors per the psychiatrist recommendations but the NP did not want to due to his recurrent urinary tract infections (UTI) in January, February, and March of 2014. The DON stated, "I don't know why, out of the blue, why she put him on Risperidone.</p> <p>During an interview on 5/2/2014 at 10:21 A.M., Nurse Practitioner #1 indicated she prescribed the anti-psychotic medication Risperidone for Resident #67 because staff had verbally reported to her he had exhibited symptoms of "Sundowners." She stated, "...I pick a medication by their symptoms. If patients with Alzheimer's are presenting with symptoms of depression I pick an anti-depressant. If they are presenting with behaviors of combativeness to the point it bothers others-a mood stabilizer. If low memory, hallucinations, paranoia, usually around shift change, I pick a low dose anti-psychotic..."</p> <p>A policy titled "Psychopharmacological Medication Use" dated 12/1/07, and identified as current by the Social Service Director on 5/1/2014 at 1:50 P.M., indicated, ".... When Physician/Prescribe orders a psychopharmacological medication for a resident, Facility should ensure that Physician/Prescriber has conducted a comprehensive assessment</p>		<p>Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p><b><u>By what date the systemic changes will be completed?</u></b></p> <p>- June 1, 2014</p>				

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	<p>of the resident and has documented in the clinical record that the psychopharmacological medication is necessary.... Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions...."</p> <p>3.1-48(a)(4) 3.1-48(b)(1)</p>			

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F000371 SS=F	<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, interview, and record review the facility failed to prepare food under sanitary conditions, and maintain drinking glasses in a sanitary manner for 1 of 2 dietary observations.</p> <p>Findings include:</p> <p>During initial dietary tour with the Dietary Manager on April 28, 2014 which began at 10:37 a.m., the following was observed:</p> <p>a. Dietary Aid #1 while wearing gloves,</p>	F000371	<p><b>F-371</b></p> <p>It is the practice of this facility to comply with F-371 – Food Procure, Store /Prepare/Serve-sanitary</p> <p><b><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u></b></p> <p>- No residents were affected as a result of this alleged finding.</p> <p><b><u>How other residents having the potential to be affected by the</u></b></p>	06/01/2014

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	<p>was observed removing slices of bed from commercial bread sacks and placing one piece at a time into individual wax paper bags for the noon meal service. The aide was observed to handle the exteriors of the bread wrappers and with the same gloves continue to handle the bread and place into bags.</p> <p>b. During the same tour with the Dietary Manager, 7 of 25 four ounce glasses, stored as clean, were observed with heavily stained interiors. The manager indicated they are bleached and/or replaced with new at times.</p> <p>A facility policy provided by the DON on 5/2/11 at 11:00 a.m., titled "Sanitation and Infection Control" dated 3/2010, included, but was not limited to, "4. Ready-to-eat food must not be touched with bare hands. Disposable gloves, tongs, or other dispensing devices must be used properly to handle food."</p> <p>3.1-31(i)(3)</p>		<p><b><u>same deficient practice will be identified and what corrective action(s) will be taken:</u></b></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>Glasses being used in the facility for the residents have been cleaned to remove any stains or have been replaced. Dietary staff handling food are using proper technique in accordance with sanitation guidelines of the dietary company.</p> <p>Dietary Manager/designee will monitor, utilizing an audit tool, for the proper method of bagging bread five times a week, until three weeks of zero negative findings are achieved. Afterwards random monitoring will occur weekly ongoing.</p> <p>Dietitian/designee will monitor, utilizing an audit tool, for cleanliness of the glasses five times a week, until three weeks of zero negative alleged findings are achieved. Afterwards random monitoring will occur weekly ongoing.</p> <p>- <b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u></b></p> <p>- Dietary Staff were educated on the sanitation policy, proper</p>		

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F000411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.		<p>technique of bagging bread, glove usage and method of cleaning glasses by the Dietary Manager.</p> <p>Dietary staff who fails to comply with these company guidelines will be educated and/or progressively disciplined as indicated.</p> <p>-</p> <p><b><u>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:</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>-</p> <p><b><u>By what date the systemic changes will be completed:</u></b></p> <p>- June 1, 2014</p>		

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	<p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on interview, and record review, the facility failed to assist a resident in obtaining dental services for 1 of 3 residents in a survey sample of 6 residents reviewed for dental services.</p> <p>Findings include:</p> <p>On 04/29/2014 3:35 p.m., in an interview Resident #53 indicated that he needed to see a dentist, due to having broken teeth, on both the left and right side of his mouth. The resident indicated that the broken teeth were uncomfortable for him when he would eat. He also indicated he was supposed to have a dental appointment, but it has been canceled several times over the last few months. He was unsure when he would be seen by a dentist. He indicated he has had these broken teeth for several months.</p> <p>In an interview on 05/01/2014 at 10:13</p>	F000411	<p>F411</p> <p>It is the practice of this facility to comply with F411 Routine/Emergency Dental Services</p> <p><b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>- Resident #53 was seen by the dentist on 5.15.2014. The dentist recommended he see an oral surgeon for a non-emergent extraction. Oral surgery appointment is pending. Please note, that in January 2014, resident refused this same extraction.</p> <p>- <b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b></p>	06/01/2014			

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	<p>a.m. the Social Services Assistant indicated, the Dentist comes every other month depending on if there is an emergency, or there are semi annual check ups for each resident. Social Services makes the appointments and can send residents out if there is a problem or they want to be seen by another dental service.</p> <p>A record review of a document dated, 10/29/13 from Resi-Dent, provided by the DON on 5/1/14 at 2:05 p.m., indicated Resident #53's appointment had to be canceled, "Pt. [sic], is on coumadin therapy and takes 6.5 mg daily that needs to be held prior dental treatment as it was in the past per MD's prescription...."</p> <p>A record review of document dated 1/2/14 from Resi-Dent, provided by the DON on 5/1/14 at 2:05 p.m., indicated, "Prophy recall will be rescheduled. Pt [sic] is on Coumadin therapy and needs clearance from MD whether or not the medication needs to be held before dental treatment as it was in the past. Pt's [sic] nurse notified and will clear the situation with the doctor before next visit."</p> <p>A record review of document dated 1/2/14 from Resi-Dent, provided by the DON on 5/1/14 at 2:05 p.m., indicates, "Prophy recall will be rescheduled. Pt</p>		<p>- Residents who reside in this facility have the potential to be effected by this alleged finding. An audit was completed on residents in reference to dental concerns noted in Section L of the most recent RAI. No emergency dental concerns were identified. Residents identified as having a dental concern will be scheduled to see the dentist within a timeframe commensurate with the concern.</p> <p>DCD/designee will monitor, utilizing an audit tool, Section L for any dental concerns not already voice to the Licensed nurse or the Certified aide.</p> <p>This monitoring will continue ongoing.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>Licensed nurses and Certified aides will be educated on signs and symptoms of what could be a potential dental concern or emergency, and protocol to follow to ensure the resident's dental need is met.</p> <p>Licensed nurses will be educated on resident assessment, documentation and follow through of findings related to dental</p>				

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F000441 SS=E	<p>[sic] is on Coumadin therapy and needs clearance from MD whether or not the medication needs to be held before dental treatment as it was in the past. Pt's [sic] nurse notified and will clear the situation with the doctor before next visit."</p> <p>3.1-24(a)(1)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>		<p>concerns.</p> <p>Licensed nurses who fail to comply with expectation of assessment, documentation and follow through will be re-educated and/or progressively disciplined as indicated.</p> <p>- <b><u>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;</u></b></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>- <b><u>By what date the systemic changes will be completed;</u></b></p> <p>- June 1, 2014</p>		

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	<p>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 transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to maintain hand hygiene to prevent cross contamination, and failed to maintain clean tablecloths in a way to prevent contamination for 1 of 1 dining observation.</p>	F000441	<p><b>F 441</b></p> <p>It is the practice of this facility to comply with F 441 Infection Control, Prevent Spread, Linen</p> <p><b><u>What corrective actions(s) will be accomplished for those residents found to have been</u></b></p>	06/01/2014

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	<p>Findings include:</p> <p>1. During a dining observation in the North Dining Room on 4/28/2014 at 12:20 p.m., CNA #4 was observed to handwash for 11 seconds. She was then observed to serve meal trays to residents in the dining room.</p> <p>2. During an observation in the North Dining Room on 4/28/2014 at 1:25 p.m., Housekeeper #5 was observed to remove the tablecloths from the dining room tables and fold each tablecloth by holding it up against her uniform and then stacked these folded tablecloths in a pink basin with napkins on the table nearest to the kitchen entrance. During an interview with Housekeeper #5 at this same time, she indicated she had set the tables up with the clean tablecloths but had found out there was a scheduled Bingo activity in this same North Dining Room. She indicated she had to remove the tablecloths for the Bingo activity and would reapply these same tablecloths after the Bingo activity.</p> <p>During an interview with the Housekeeping Director on 5/2/2014 at 3:35 p.m., she indicated she did not see a problem with the clean tablecloths touching the employee uniform.</p>		<p><b><u>affected by the deficient practice?</u></b></p> <p>- No residents were affected as a result of this alleged finding.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- Residents who reside in this facility have the potential to be affected by the alleged finding related to hand washing and handling of clean linen.</p> <p>Facility staff was educated on Hand Hygiene, with emphasis on washing hands for the 15 seconds per facility guidelines.</p> <p>Each Department head or designee, utilizing an audit tool, will observe three staff every shift for one week for proper techniques of hand washing until three weeks of zero negative findings are achieved. Findings will be addressed as found.</p> <p>Housekeeping Supervisor, utilizing an audit tool, will observe placement of table linen three times a week in North and South dining rooms.</p> <p>Observed break in infection control technique handling of clean linen will be addressed and corrected immediately with the</p>	

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	<p>The "How to Handwash?" policy dated 5/2013 was provided by the Unit Manager #9 on 5/1/2014 at 2:15 p.m. This current policy indicated the following:</p> <p>" ...Hand Hygiene (CONT.) Guidelines For Hand Hygiene Hand hygiene has been proven to reduce the risk of infections .... Handwashing with soap and water: ...apply soap and lather ...for at least 15 seconds; ... Use antimicrobial or non-antimicrobial soap and water in the following situations: ...* after contact with blood or body fluids .... "</p> <p>The "Folding Guidelines" current policy was provided by the Administrator on 5/2/2014 at 4:15 p.m. and the "Clean Linen Delivery Guidelines" current policy was provided by the DON on 5/2/2014 at 4:00 p.m. Both policies were reviewed on 5/2/2014 at 4:15 p.m. and did not provide guidelines for folding clean tablecloths against employee uniforms.</p> <p>3.1- 18(l) 3.1- 19(g)</p>		<p>staff person, with education, and/or disciplinary action.</p> <p>Monitoring will continue ongoing.</p> <p>- <b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Facility staff will be educated on guidelines for proper hand hygiene and handling clean linen.</p> <p>Facility staff who fails to comply with these facility guidelines will be educated and/or progressively disciplined as indicated.</p> <p><b><u>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:</u></b></p> <p>Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/ADNS. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p>				

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