STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE THE	2400 CHATEAU DR MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This survey was for a Recertification and State Licensure Survey. Survey Dates: February 25, 26, 27, 28 and March 3, 2014 Facility number: 000310 Provider number: 155443 AIM number: 100288970 Survey team: Karen Lewis, RN, TC Ginger McNamee, RN Tina Smith-Staats, RN Toni Maley, BSW (2/25/14, 2/26/14, 3/3/14) Census bed type: SNF/NF: 44 Total: 44 Census payor type: Medicare: 6 Medicaid: 32 Other: 6 Total: 44 These deficiencies also reflect state findings in accordance with 410 IAC 16.2 Quality review completed by Debora Barth, RN.	F000000		

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

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

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure 1 of 11 residents interviewed was given a choice of the number of showers they received a week. (Resident #12) Findings include: Resident #12 was screened as interviewable and interviewed on 2/25/14 at 10:23 a.m. The resident indicated she would like to have a shower every other day and was told there were too many patients for her to have a shower that often. The clinical record for Resident # 12 was reviewed on 2/28/14 at 11:48 a.m. The annual Minimum Data Set, dated 2/2/14, indicated it was "very important" for the resident to choose her own bathing preference.	F000242	**F 242** It is the intent of this facility to ensure that residents choose their activities, schedules, and healthcare decisions of his/her life in the facility. 1. On 3/3/14, Resident #12 was interviewed to update her shower preferences. 2. By 3/3/14, current residents were interviewed to update their shower preferences. All shower sheets were updated to reflect these specific requests. 3. DON or designee will monitor to ensure residents are being provided their showers according to updated shower sheets. Shower sheets will be monitored daily for 6 weeks, then 3 times per week for 4 weeks, then weekly. 4. DON/Designee will monitor the audit sheets 5 times weekly for 6	03/17/2014

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	During an interview with the Director of Nursing on 2/28/14 at 9:22 a.m. She indicated residents were told they get a shower two times a week. 3.1-3(u)(1)		weeks, then 3 times per week for 4 weeks, then weekly. Report of monitoring will be reported to QAA committee on quarterly basis. 5. Date of Completion: 3/17/2014	
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure laboratory tests were obtained timely as ordered by the physician for 1 of 5 residents reviewed for laboratory testing related to medication use. (Resident #36) Findings include: The clinical record for Resident #36 was reviewed on 2/27/14 at 8:04 a.m. Diagnoses for Resident #36 included, but were not limited to, diabetes, hyperlipidemia, and hypertension. The clinical record indicated Resident #36 was to have a Fasting Lipid Profile (FLP) every 6 months	F000282	**F282** It is the intent of this facility to ensure laboratory testing is obtained timely as ordered by the physician. 1. On 3/6/14 Resident #36 laboratory order was obtained. Results are present within the clinical record. 2. 100% review of all lab orders was completed. Review of all labs revealed no other residents affected. 3. Licensed nurses educated on laboratory policy and new lab tracking procedure on March 13, 2014. 4. DON/Designee will monitor results of laboratory tracking 5 times	03/17/2014

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	due in February and August. The original date for the laboratory test was 9/17/13. The clinical record lacked any results for a February, 2014, FLP laboratory test for Resident #32. During an interview with the Director of Nursing, on 3/3/14 at 11:19 a.m., additional information was requested related to the lack of a February, 2014, FLP laboratory results for Resident #36. During an interview with the Director of Nursing, on 3/3/14 at 3:35 p.m., she indicated the FLP laboratory tests had not been drawn in August of 2013, or in February, 2014, as ordered by the physician. A current, 7/1/11, facility policy titled "Laboratory Tests", provided by the Administrator on 3/3/14 at 12:50 p.m., indicated the following: "It is the intent of the facility that Laboratory tests are completed on all residents as ordered by the physician." A current, 7/1/11, facility policy titled "Lab Scheduling and Tracking", provided by the Administrator on 3/3/14 at 12:50 p.m., indicated the following:		weekly for 6 weeks, then 3 times per week for 4 weeks, then weekly. 5. Date of Completion: 3/17/14	

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	" It is the intent of the facility that all laboratory tests ordered by the physician will be systematically scheduled and tracked to ensure that all lab work is obtained and results are received. ...3 Health records will log all Lab Requisitions for all routine lab work needing to be done, at least weekly, or depending on the needs of the individual facility. ...7 The Lab Requisitions will be placed in the lab book on the unit prior to the approximate date the lab is due to be obtained. ...11 When the lab has been obtained, the phlebotomist indicates this in the lab book as well as on the Lab Requisition. One copy of the Lab Requisition is to remain in the lab book. ...14 Any labs not obtained as indicated will be re-scheduled and the physician will be notified as needed. ...19 If the lab draw was omitted the lab will be contacted to perform the test and the physician will be contacted if indicated." 3.1-35(g)(2)			

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F000329 SS=D	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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and 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.			
	Based on record review and interview, the facility failed to ensure bowel monitoring was completed so interventions to relieve constipation could be given for 2 of 5 residents reviewed for unnecessary medications. (Residents #8 and #50) 1.) The clinical record for Resident #50 was reviewed on 2/27/14 at 10:05 a.m. Diagnosis for the resident included, but were not	F000329	**F 329** It is the intent of this facility to ensure it identifies and implements plans of action for items such as Bowel monitoring. 1. Resident #8 and Resident #50's MD orders reaffirmed and care plans reviewed for medication regimen and bowel activity for these residents. 2. Review completed of bowel	03/17/2014

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	limited to, decreased bowel motility, hypertension, and Alzheimer's type dementia with delusions and behaviors. An admission Minimum Data Set (MDS), dated 1/28/14, indicated Resident #50 was severely cognitively impaired. A health care plan, dated 4/19/13, indicated Resident #50 had decreased bowel motility. One of the goals for this problem was the resident would have a bowel movement every 2-3 days. Interventions for this problem included administer medications per order, and record bowel movements. Current physician orders for Resident #50 included, but were not limited to, the following orders: a.) Colace (a stool softener) 100 milligrams (mg) by mouth daily. The original date of this order was 1/14/14. b.) Bisac-evac suppository (a laxative) 10 mg 1 suppository rectally once a day as needed for decreased bowel motility. The original date of this order was 1/14/14.		monitoring section in EMR for current residents to assure appropriate bowel Activities within the last 72 hours in order to identify other affected residents, and no other residents identified. 3. DON/Designee will review EMR to monitor Bowel Alerts to indicate residents receiving stool softeners, laxatives, etc. and Care plans will be reviewed and updated for current orders related to bowel activity. Licensed nurses educated on bowel elimination policy. 4. Bowel activity alerts from the EMR will be taken to CQI meeting 5 times weekly to assure licensed nurses will implement bowel protocol per MD order. DON/designee will audit records of 3 residents weekly for 12 weeks to ensure proper implementation of bowel elimination policy. Findings will be reported to QAA committee. 5. Date of Completion: 3/17/14	

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	c.) Milk of Magnesia (a laxative) 30 milliliters (ml) by mouth once daily as needed for decreased bowel motility. The original date of this order was 1/14/14. Review of the past 90 days of bowel monitoring indicated Resident #50 did not have a bowel movement for the following time periods: February 6, 7, 8, 9, and 10, all ones recorded or blank spaces. A one indicated "none" for the size of bowel movements. A time period of 5 days without a recorded bowel movement. February 13, 14, 15, and 16, all ones recorded or blank spaces. A time period of 4 days without a recorded bowel movement. The nursing notes lacked any information related to any interventions having been given or tried during these time periods. Review of the February 2014 Medication Administration Record (MAR) indicated no as needed medications for decreased bowel motility were given in the month of February 2014. An as needed			

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	medication, Haldol (an antipsychotic), was given two times on February 15 for agitation and an increase in behaviors. During an interview with the Director or Nursing on 3/3/14 at 10:17 a.m., additional information was requested related to the bowel monitoring for Resident #50. During an interview with the Director of Nursing on 3/3/14 at 10:48 a.m., she indicated if the nurse had reviewed the bowel monitoring for Resident #50 the as needed medications would have been given per physician order. She indicated bowel monitoring for Resident #50 was one of the items that should have been reviewed when the resident was displaying behaviors. 2.) Resident #8's clinical record was reviewed on 2/27/14 at 8:55 a.m. The resident's diagnoses included, but were not limited to, bipolar with psychosis, dementia, and personality disorder with narcissistic features. The resident had current physician's orders for: Docusate sodium 100 mg capsule for decreased bowel motility give 1 capsule every other day by mouth. Miralax for constipation			

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	dissolve 1 capful (17 gm) in 8 ounces of water and take by mouth once daily. Milk of Magnesia (a laxative) take 30 milliliters by mouth once daily as needed for constipation. Review of the February, 2014, Medication Administration Record indicated the resident received the docusate sodium capsule every other day as ordered and Miralax once daily as ordered. There was no indication the resident received the Milk of Magnesia. Review of the February, 2014, Bowel Monitoring Log indicated the resident did not have a bowel movement on February 4, 5, 6, 7, 8, and 9, 2014. This resulted in no bowel movements for six days. Review of the Nurse's Notes lacked any indication of the resident having a bowel movement. Additional information related to the lack of bowel movements was requested from the Director of Nursing on 3/3/14 at 10:45 a.m. During an interview with the Director of Nursing on 3/3/14 at 2:42 p.m., she indicated she had no additional			

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	information to provide. 3.) A current, 7/1/11, facility policy titled "Bowel Elimination Policy", provided by the Director of Nursing on 3/3/14 at 3:39 p.m., indicated the following: "It is the intent of the facility nursing personnel to document, monitor and implement appropriate measures relative to the management of bowel function. ...5. The Charge Nurse will review all ADL sheets in regards to bowel movements. If a resident has no bowel movement by the third day, the Charge Nurse will notify the MD and follow ordered protocol. 6. The Charge Nurse will document the intervention offered." A current, 11/10, facility policy titled "Behavior Program Policy & Procedure", provided by the Administrator in 3/3/14 at 12:50 p.m., indicated the following: "...new or worsening behaviors shall be reviewed promptly." 3.1-37(a)			

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F000334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on interview and record review, the facility failed to provide evidence of annual education for the Influenza vaccine for 5 of 5 residents reviewed. (Resident #26, Resident #28, Resident #29, Resident #36 and Resident #49). Findings include: 1. The record review for Resident #26 on 2/28/2014 at 10:30 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #26 receiving the Influenza	F000334	F334 It is the intent of this facility to assure that each resident is informed about the benefits and risks of immunizations and has the opportunity to receive, unless medically contraindicated or refused or already immunized, the influenza and pneumococcal vaccine. 1. On 3/12/14 Resident's # 26, 28, 29, and 36 were provided education of influenza and pneumonia vaccines as well as given the opportunity to accept or decline immunizations. Res #49 no longer in	03/14/2014

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	vaccine on 12/2/2013. 2. The record review for Resident #28 on 2/28/2014 at 10:30 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #28 receiving the Influenza vaccine on 11//6/2013. 3. The record review for Resident #29 on 2/28/2014 at 10:30 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #29 receiving the Influenza vaccine on 12/1/2013. 4. The record review for Resident #36 on 2/28/2014 at 10:30 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #36 receiving the Influenza vaccine on 12/6/2013. 5. The record review for Resident #49 on 2/28/2014 at 10:30 a.m., indicated no evidence of education for the Influenza vaccine was given to the resident or the family prior to Resident #49 receiving the Influenza vaccine on 12/11/2013. 6. During an interview on 3/3/2014		facility. 2. Current resident charts have been audited to ensure all consents are up to date. 3. Upon admission and yearly, residents will receive education of influenza and pneumonia vaccines as well as be given the opportunity to accept or decline immunizations. 4. DON/Designee will monitor new admissions weekly for 12 weeks to ensure compliance. Results of these findings will be reported to the QAA committee. 5. Date of Completion: 3/14/14	

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	at 8:30 a.m., with the Director of Nursing, she indicated there was no documentation supporting education was given to residents or their families prior to being given the Influenza vaccine. During the Resident Council interview on 3/3/2014 at 1:40 p.m., the Resident Council President indicated she had received the Influenza vaccine for the 2013-2014 influenza season. She indicated she had not received any education regarding the Influenza vaccine prior to receiving the vaccine. The record review had no documentation of any education being given to the Resident Council President or her family prior to the vaccination. Review of the current, dated 7/1/2011, immunization policy entitled "Influenza and Pneumococcal Immunization", provided by the Director of Nursing on 3/3/2014 at 8:30 a.m., included, but was not limited to, the following: "...Influenza Immunization... The consent and need for the resident to receive the Influenza vaccine will be confirmed per the following: Checking the resident			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immunization history (if available)... c. Verify that consent was given for the resident to receive the vaccine and that education as to the risks and benefits was provided..." 3.1-18(b)(5)			
F000364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on record review, interview, and observation, the facility failed to ensure the food served to residents was at an enjoyable temperature for 8 of 11 residents interviewed for food temperature. (Resident #'s 12, 46, 43, 26, 39, 10, 40, 52) Findings include: An observation of the serving line was made on 2/27/14 at 11:58 a.m., Dietary staff member #2 was serving food from the steam table. She was removing plates from the plate warmer with her bare hands. She indicated the plates from the top of the warmer are not as hot as the plates lower in the unit. She	F000364	F364 It is the intent of this facility to ensure the food served to residents is at an enjoyable temperature. 1. All residents have the potential of being affected by this deficient practice. Temperature settings of plate warmer have been set at an appropriate temperature requiring dietary staff to utilize suction tool for plate handling. 2. All residents have the potential of being affected by this deficient practice. 3. Plate warmer has been set at an appropriate temperature requiring dietary staff to utilize	03/14/2014

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	indicated the plates are never so hot as to require picking them up with a suction tool. The plates felt barely warm to touch. The plates were placed in plastic plate covers and placed on trays in an enclosed metal cart for transportation to the dementia unit. Dietary staff member # 2 indicated she had not had any complaints about cold food. A test tray was requested to be sent on the cart. The temperature of the test tray was measured when the last tray on the cart was served at 12:10 p.m. The meat was warm to taste. The temperature measured 128 degrees Fahrenheit per the Dietary Manager. She indicated all 44 residents living in the facility received meals from the dining room. The following residents were screened to be interviewable during the Stage I survey process and indicated the following: 2/25/14 at 10:27 a.m., Resident #12 indicated she ate in the dining room and the food was cold when she got it. 2/25/14 at 2:04 p.m., Resident #46 indicated the food was served cold.		suction tool for plate handling. 4. DSM will monitor plate warmer setting 5 times a week for 6 weeks and then weekly for 6 weeks. Results of findings will be brought to QAA committee. 5. Date of Completion: 3/14/14	

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	2/25/14 at 10:07 a.m., Resident #43 indicated the food was frequently cold. She indicated she ate breakfast in her room and lunch and dinner in the dining room. 2/25/14 at 11:20 a.m., Resident #26 indicated she ate in her room and the food was cold 50% of the time. 2/25/14 at 2:16 p.m., Resident #39 indicated he ate in the dining room and 75% of the time the food was cold. 2/25/14 at 10:02 a.m., Resident #10 indicated she ate in the dining room and the food was cold 75% of the time. 2/25/14 at 10:19 a.m., Resident #40 indicated she was the last one to get her tray and it was usually cold. 2/25/14 at 9:49 a.m., Resident #52 indicated the food was never hot. During an interview with the Administrator on 2/28/14 at 10:20 a.m., she indicated the plate warmer was not being turned up on high. She indicated the warmer should be set on high and the plates should come out too hot to handle with bare			

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	hands. 3.1-21(a)(2)			
F000371 SS=F	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 and interview, the facility failed to ensure the surfaces of the pans and skillets were free from stains and were smooth for 2 of 2 kitchen observations and failed to ensure supplements were not served past their expiration dates (Residents # 5, 6, and 8). These deficient practices had the potential to affect 44 of 44 residents receiving meals from the kitchen. Findings include: 1.) During the initial kitchen tour with the dietary manager on 2/25/14 at 8:38 a.m., 3 skillets were observed. The Dietary Manager indicated the skillets were used regularly for meals. Each skillet had a dark coating on the cooking surface. The center of the cooking	F000371	F371 It is the intent of this facility to ensure supplements are served under sanitary conditions. Also those surfaces of pans and skillets are smooth and free from stains. 1. All residents were found to be potentially affected by this deficient practice. On 2/28/12 all pots, pans, and skillets in need of replacing were replaced. On 3/3/14 all dietary supplements found to be beyond the expiration date were discarded. 2. All residents were found to be potentially affected by this deficient practice. On 2/28/12 all pots, pans, and skillets in need of replacing were replaced. On 3/3/14 all dietary supplements found to be beyond the expiration date were discarded. 3. DMS/Designee will perform kitchen sanitation audits to ensure appropriate pots, pans, and skillets are available for food preparation. DON/Designee will inspect dietary supplements to ensure dates are prior to expiration date. 4.	03/14/2014

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	surface had the finish worn off down to the shiny metal. There were 3 sauce pans and a large soup pot stored as clean with brown stains built up on the cooking surfaces. The Dietary Manager indicated she would need to contact her supervisor about the condition of the skillets, pots and pans. A kitchen observation was made on 2/27/14 at 10:02 a.m., 2 of the skillets with the worn cooking surfaces were on the drying rack of the 3 basin sink. The third worn skillet, the 3 stained sauce pans and the stained soup pot were stored ready for use. During an interview with the administrator on 2/28/14 at 10:20 a.m., she indicated she had been told the pots and pans had age on them but was not aware of the finish being worn off. The Administrator was interviewed on 3/3/14 at 11:16 a.m. She indicated the Registered Dietician had been to the facility on 2/10/14 and her report indicated the pots and pans showed age and was not presented as an immediate concern. 2. During the Medication Storage observation in the 300/400 Hall		DSM/Designee will perform kitchen sanitation audits weekly for 12 weeks, DON/Designee will monitor weekly for 12 weeks to ensure dates for supplements are prior to expiration date. Results of findings will be brought to QAA committee. 5. Date of Completion: 3/14/14	

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	medication room, 3/3/2014 at 9:45 a.m., 6 boxes of unopened and 2 boxes of refrigerated, opened Ready Care 2.0 High Calorie, High Protein Supplement Drink were observed. The 2.0 high calorie, high protein supplement drink had an expiration date of 2/28/14. During an interview on 3/3/2014 at 9:45 a.m., Nurse #1 indicated the opened boxes of supplement located in the refrigerator were currently in use for three residents on the unit (Resident #5, Resident #6 and Resident #8). She further indicated the supplement was supplied to the unit by the Dietary Department. During an interview with the Dietary Manager on 3/3/2014 at 2:31 p.m., she stated, "I assumed nursing was keeping track of the Med Pass (dietary supplement), but I will take it over now." Resident #5's record was reviewed on 3/3/3014 at 10:00 a.m. Resident #5's diagnoses included, but were not limited to, dementia with delusions, hypertension, hyperlipidemia, left hip fracture and anemia. Resident #5's physician orders indicated 120 ml of Med Pass			

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	2.0 ordered for 3 times a day. The Medication Administration Record (MAR) for March 2014 also indicated the resident had been receiving the supplement as ordered. Resident #6's record was reviewed on 3/3/3014 at 10:05 a.m. Resident #6's diagnoses included, but were not limited to, anemia, seizures, hypokalemia, advanced dementia. Resident #6's physician orders indicated 120 ml of Med Pass 2.0 ordered for 4 times a day. The Medication Administration Record (MAR) for March 2014 also indicated the resident had been receiving the supplement as ordered. Resident #8's record was reviewed on 3/3/3014 at 10:10 a.m. Resident #8's diagnoses included, but were not limited to, anemia, depression, and hyperlipidemia. Resident #8's physician orders indicated 90 ml of Med Pass 2.0 ordered for 4 times a day. The Medication Administration Record (MAR) for February 2014 also indicated the resident had been receiving the supplement as ordered. 3.1-21(a)(3)			

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F000463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a resident's call light was in working order for 1 of 30 residents reviewed for functional call lights. (Resident #35) Findings include: During an observation of the resident's bathroom on 2/25/14 at 9:52 a.m., the call light would not sound after 2 separate attempts. CNA #3 was informed of the call light not working in Resident #35's bathroom. During an observation of the resident's bathroom on 2/28/14 at 9:50 a.m., the call light would not sound after 3 separate attempts. RN #4 came to the resident's bathroom and tried the call light 3 times. The call light did not sound on any attempts. The bathroom was only used by Resident #35. During an interview with the Maintenance Supervisor on 2/28/14	F000463	F463 It is the intent of this facility to ensure all resident's call lights are in working order. 1. Resident #35 call light repaired on 2/28/2014. 2. Call light audit was performed on 3/13/14 to ensure all lights are in working order. 3. Maintenance supervisor will monitor bathroom call lights weekly for 4 weeks, thereafter, all call lights will be monitored monthly for 8 weeks, then quarterly. 4. Administrator/Designee will review maintenance supervisor audits. Findings will be brought to QAA committee. 5. Date of Completion: 3/13/14	03/13/2014

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	at 10:08 a.m., he indicated he had not been informed of the malfunctioning call light in Resident #36's bathroom until 2/28/14. He further indicated all the call lights were checked in October, 2013. During an interview with RN #4 on 2/28/14 at 10:18 a.m., she indicated Resident #35 does not use the bathroom without staff assistance. An admission Minimum Data Set (MDS), dated 1/16/14, indicated the resident required the assistance of staff for toileting. 3.1-19(u)(1)			

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F000520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation and interview, the facility's Quality Assurance Committee failed to identify and address the need for prompt replacement of cooking equipment and develop an effective plan of action to address the concern. This deficient practice had the potential to impact 44 of 44 residents who ate meals prepared in the facility kitchen.	F000520	F520 It is the intent of this facility to ensure that the QA & A committee identify and implement plans of action to correct concerns ,implement of plans of action to address concerns such as worn pots and pans, and to identify and implement plans of actions for such items.	03/14/2014

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	Findings include: 1.) During the initial kitchen tour with the dietary manager on 2/25/14 at 8:38 a.m., 3 skillets were observed. The Dietary Manager indicated the skillets were used regularly for meals. Each skillet had a dark coating on the cooking surface. The center of the cooking surface had the finish worn off down to the shiny metal. There were 3 sauce pans and a large soup pot stored as clean with brown stained built up on the cooking surfaces. The Dietary Manager indicated she would need to contact her supervisor about the condition of the skillets, pots and pans. A kitchen observation was made on 2/27/14 at 10:02 a.m., 2 of the skillets with the worn cooking surfaces were on the drying rack of the 3 basin sink. The third worn skillet, the 3 stained sauce pans and the stained soup pot were stored ready for use. During an interview with the administrator on 2/28/14 at 10:20 a.m., she indicated she had been told the pots and pans had age on them but was not aware of the finish being worn off.		1. All residents were found to be potentially affected by this deficient practice. On 2/28/14, all pots, pans, and skillets were replaced. 2. All residents were found to be potentially affected by this deficient practice. On 2/28/14, all pots, pans, and skillets were replaced. 3. QA &A committee meetings will be held monthly instead of the required quarterly to Ensure the facility is keeping systems functioning satisfactorily and consistently. These meetings will include maintaining current practice standards; preventing deviation from care processes from arising, to the extent of possible; discerning issues and concerns, if any, with facility systems and determining if issues/concerns are identified; and correcting inappropriate care processes. 4. The corrective actions will be monitored by the administrator/designee on a monthly Basis during the QA & A committee meetings to ensure achieving or sustaining Desired outcomes. The monitoring will continue monthly on an ongoing basis.	

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	The Administrator was interviewed on 3/3/14 at 11:16 a.m., during the interview she indicated the Registered Dietician had been to the facility on 2/10/14 and her report indicated the pots and pans showed age and was not presented as an immediate concern. During a 3/3/14, 11:16 a.m., interview regarding the QAA Committee and the concerns with food preparation equipment, the Administrator indicated the Registered Dietitian (RD) visited for a routine monitoring visit. The Administrator indicated the RD had identified the pans were showing signs of wear during her 2/10/14 visit. She indicated the RD had not identified the finish as totally worn off or the need for prompt replacement. She additionally indicated the QAA committee did act upon recommendations made by the RD. The Administrator also indicated since the RD had not described the pots and pans as an immediate concern the QAA committee had decided they could replace them slowly over time and no plan of action had been developed to replace the pots and pans.		5. Date of completion: 3/14/14	

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	3.1-52(b)(2)			