

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/24/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00175535.</p> <p>Complaint #IN00175535 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F328.</p> <p>Survey dates: July 20, 21, 22, 23 and 24, 2015</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Census bed type: SNF/NF: 94 Total: 94</p> <p>Census payor type: Medicare: 15 Medicaid: 66 Other: 13 Total: 94</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with respect and dignity related to entering a room without permission and during dining for 2 of 51 residents observed for dignity. (Resident #24, Resident #99)</p> <p>Finding includes:</p> <p>On 7/21/15 at 10:37 A.M., LPN (Licensed Practical Nurse) #5 was observed entering Resident #24's room without knocking.</p> <p>On 7/21/15, between 12:10 P.M. and 12:46 P.M., CNA (Certified Nursing Assistant) #6 was observed to assist Resident #99 with feeding. At no time was he observed to make conversation with the resident.</p>	F 0241	<p>Corrective action for resident #24 and resident #99 cannot be accomplished. All residents have the potential to be affected by the deficient practice. Staff in all departments will be educated on the Dignity, Resident Rights Guidelines and Procedure. Nursing staff will be educated on Feeding Policy and Procedure. Executive Director or Designee will conduct audits of staff entering residents' rooms after gaining permission. Audits will include audits on day shift, evening shift, and night shift 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Executive Director or Designee will conduct audits of staff assisting residents with feeding while engaging residents in appropriate conversation. Audits will include breakfast, lunch, and dinner meals 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Results of these audits will be reviewed and</p>	08/23/2015

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F 0272 SS=D Bldg. 00	<p>On 7/22/15 at 4:00 P.M., review of the current policy titled "Dignity, Resident Rights Guidelines and Procedure #58 Feeding," dated 2/26/15, provided by the Executive Director, indicated "Promoting independence and dignity in dining... If a resident is in his/her room, knock on the door, wait for a response and identify yourself...12. Make conversation with the resident; Atmosphere should be pleasant...."</p> <p>During an interview on 7/23/15 at 1:40 P.M., the Director of Nursing indicated "... CNA's that are assisting feeding residents should be conversing with them through out the meal...."</p> <p>3.1-3(t)</p> <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;</p>		discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.		

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	<p>Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information 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 record review and interviews, the facility failed to ensure a thorough, accurate assessment of pressure areas was completed for 1 of 3 residents reviewed for pressure ulcers. (Resident #76) The facility also failed to complete an accurate and timely assessment of a contracture for 1 of 1 residents reviewed for range of motion needs. (Resident #34)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #76 was reviewed on 07/23/2015 at 9:39 A.M. Resident #76 was admitted to the</p>	F 0272	<p>Corrective action for resident # 76 is unable to be accomplished as resident has been discharged from living center. Corrective action for resident # 34 has been accomplished by providing range of motion to lower extremities including 15 repetitions to lower extremities on day and evening shift each day. The care plan and CNA care guide have been reviewed and revised to indicate this. All residents have the potential to be affected by this deficient practice. Nursing staff will be educated regarding conducting the initial and periodic comprehensive, accurate, standardized, reproducible assessment of each resident's</p>	08/23/2015

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	<p>facility, on 05/11/15, with diagnoses, including but not limited to: acute renal failure, hyponatremia, anemia, depressive disorder, obstructive sleep apnea, heart failure, chronic venous hypertension, chronic airway obstruction, psoriasis, encephalopathy and hematuria.</p> <p>The admission nursing assessment, completed on 05/11/15, indicated the resident was admitted with two stage one (intact skin with nonblanchable redness of a localized area) red areas on the right and left crease in his upper buttocks/lower back area. The documentation did not measure the wounds but indicated they were due to "friction."</p> <p>The care plans, initiated on 05/16/15, indicated the resident had a physical functioning deficit and his skin was to be inspected with care and reddened or open areas were to be reported to the charge nurse.</p> <p>Another plan, initiated on 05/23/15, for a an altered skin integrity non pressure related to Excoriation. The goal was for the affected areas to heal without complications. The interventions were to conduct weekly skin inspection, skin assessments to be completed per living center policy, and treatments as ordered.</p>		<p>functional capacity. All assessments have been reviewed for accuracy. Director of Nursing or Designee will audit initial assessment of newly admitted residents to ensure comprehensive, accurate, standardized, reproducible initial assessment of resident's functional capacity 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Director of Nursing or Designee will randomly audit periodic assessments to ensure accurate, standardized, reproducible assessment of resident's functional capacity 5 assessments weekly for 4 weeks; 3 assessments weekly for 4 weeks; 1 assessment weekly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>	

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	<p>The MDS (Minimum Data Set) assessment, completed on 05/18/15, for his admission assessment indicated the resident had two stage one pressure ulcers.</p> <p>The MDS assessment, dated 05/25/15 for 14 day Medicare, indicated the resident was not marked as having any pressure ulcers.</p> <p>The wound documentation, located by the Director of Nursing on 07/23/2015 at 11:06 A.M. , indicated, on 05/16/15, a 2.0 cm (centimeter) by 1.0 cm blanchable area was noted on the resident's coccyx. The form indicated the area had been incorrectly identified as a stage one pressure ulcer on the admission. During an interview with the DON, on 07/23/15 at 11:06 A.M. regarding why the area identified on the 05/16/15 form did not match the two areas identified on the admission record, she indicated she was not aware of the issue and she could not ask the nurse who had completed the assessment because she was no longer employed by the facility.</p> <p>2. On 07/22/2015 at 11:43 A.M., Resident #34 sat in his wheelchair in his room. The resident's back was kyphotic and he slumped to the right side in his</p>			

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	<p>wheelchair. His legs were crossed and bent at the knees. He was holding his head in his hands.</p> <p>The 06/21/15 quarterly Minimum Data Set (MDS) assessment indicated Resident #34 had no range of motion limitations.</p> <p>During an interview on 07/23/2015 at 2:13 P.M., LPN #20 indicated the resident's knees were contracted as he kept one knee extended and the other knee bent. She could not locate any care plan regarding any interventions to provide range of motion services for the resident or any specific care of his lower extremity contracture's.</p> <p>During an interview on 07/24/15 at 10:00 A.M., the DON indicated Resident #34's left knee was contracted. She did not know how contracted or how limited his range of motion was in the affected knee.</p> <p>During an interview on 07/24/15 at 10:25 A.M., the DON indicated therapy "screened" the resident quarterly for any needs. She was not aware of when the last evaluation regarding his contracture.</p> <p>3.1-31(a)</p>			

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F 0282 SS=D Bldg. 00	<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 record review and interviews, the facility failed to ensure the physician's orders were followed regarding medications and failed to ensure a significant medication error did not occur related to blood pressure medication being omitted for 1 of 3 residents reviewed for hospitalization. (Resident #39) In addition, the facility failed to ensure a rapid acting insulin (Humalog) was administrated within 15 minutes of mealtime. (Resident #13) Finally, the facility failed to ensure the hospital physician's orders were followed regarding urostomy care for 1 of 1 residents reviewed for ostomy care. (Resident #B)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #39 was reviewed on 07/22/15 at 2:35 P.M. Resident #39 was admitted to the facility on 05/22/15, with diagnoses, including but not limited to, sepsis, hypothyroidism, diabetes, acidosis,</p>	F 0282	<p>Corrective action for resident #39 included reviewing hospital physician's orders for readmission to living center and verifying these orders with attending physician at living center. Corrective action for resident #13 included obtaining order to check blood sugar prior to administering rapid acting insulin. Corrective action for resident #B is unable to be accomplished as resident has been discharged from living center. All residents have the potential to be affected by this deficient practice. Licensed nurses will be educated on order transcription. Admission orders will be verified by a second licensed nurse upon admission before orders are communicated to pharmacy. Licensed nurses will be educated on administration of rapid acting insulin after obtaining resident's blood sugar per physician's order within 15 minutes of meal being served or with juice and snack upon resident's request. Residents may request insulin prior to 15 minutes before the meal is</p>	08/23/2015

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	<p>dementia, generalized anxiety disorder, hypertension, atrial fibrillation, acute cholecystitis and chronic kidney disease.</p> <p>The physician's orders for medications, noted on the 05/22/15, acute care center's transfer documentation, indicated the resident was to continue to receive Metoprolol (a blood pressure and heart medication) 50 mg (milligrams) every 12 hours and Levothyroxine .175 mg one tablet once a day.</p> <p>The facility "order summary report," completed on 05/22/15, indicated the Metoprolol medication was omitted from the order report and the Levothyroxine dose was documented as "75 mcg [microgram]" instead of .175 mg.</p> <p>The May 2015 and the June 2015 Medication Administration Records confirmed the Metaprolol was not administered to Resident #39 as ordered and the incorrect dose of 75 mcg of Levothyroxine medication was administered to Resident #39.</p> <p>An acute care History and Physical report, dated 06/19/15, indicated Resident #39 was readmitted to the acute care facility due to shortness of breath and an elevated heart rate. The resident's heart rate on arrival was 172 beats per</p>		<p>served. When rapid acting insulin is requested by the resident prior to the 15 minute time frame, rapid acting insulin will be administered with juice and a snack. The time of rapid acting insulin administration has been changed to appropriate meal times. Staff in all departments will be educated on providing care in compliance with comprehensive care plans will that will be developed by the interdisciplinary team (IDT) within 9 days of admission to include but not limited to treatment/care of any ostomy, impaired skin, functional limitation, psychosocial needs, nutritional needs, and identified risk factors. Director of Nursing or Designee will audit hospital physician orders and ensure accuracy of admission orders 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Director of Nursing or Designee will audit administration of rapid acting insulin after obtaining blood sugar per physician's order to ensure appropriate administration time of rapid acting insulin for resident's receiving rapid acting insulin 5xweek for 4 weeks; 3x week for 4 weeks; 1xweek for 4 months. IDT will audit care plans for all newly admitted residents within 9 days of admission to ensure accurate and complete care plan has been developed for 6 months. Results of these audits will be reviewed and discussed in monthly Quality</p>	

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	<p>minute. She was also diagnosed with acute respiratory insufficiency, suspected congestive heart failure exacerbation, atrial fibrillation in rapid ventricular rate and an elevated TSH level (thyroid stimulating hormone).</p> <p>Interview with LPN #20 on 07/22/15 at 2:45 P.M. confirmed the transfer orders from the acute care center for Resident #39 did not match the transcribed order summary report. She confirmed there was no Metoprolol and the Levothyroxine dose did not match.</p> <p>2. On 7/23/15 at 11:34 A.M., Resident #13 was injected with 6 units of Humalog (rapid acting insulin) by LPN #2. There was no order to check the resident's blood sugar prior to receiving her insulin.</p> <p>On 7/23/15 at 11:50 A.M., Resident #13 was observed in her room, there was no juice or food in the room with the resident. The resident was observed going thru her bedside table items.</p> <p>On 7/23/15 at 12:08 A.M., Resident #13 was observed in her room and CNA #3 passed the resident's room with hall trays.</p> <p>On 7/23/15 at 12:10 P.M., Resident #13 was observed in a wheelchair and being taken to the dining room and was left at</p>		Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.				

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	<p>table with no food or drink. At 12:20 P.M. the resident was given a meal and drinks. Resident did not attempt to eat and was not observed to take eating utensils out of her napkin until 12:25 P.M.</p> <p>During an interview, on 7/23/15 at 12:14 P.M., LPN #2 indicated after administering a rapid acting insulin the resident should have food or drink within 30 minutes.</p> <p>On 7/23/15 at 2:40 P.M., RN #4 provided a copy of Epocrates (an online drug reference) for Humalog (lispro insulin). The Epocrates indicated "...Insulin lispro is a fast-acting medicine that begins to work very quickly. After using insulin lispro you should eat a meal within 5 to 10 minutes..." RN #4 further indicated each nurse had access to the Epocrates on their desk top.</p> <p>On 7/23/15 at 3:04 P.M., RN#4 provided a policy titled, "Diabetes Management," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...RAPID ACTING INSULINS [Humalog (lispro), NovoLog (aspart), Apidra (glulisine)] In general, administration must occur within 15 minutes of mealtime due to rapid action..."</p>			

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	<p>3. On 7-22-2015 at 1:08 P.M., Resident #B's clinical record was reviewed and indicated an admission date of 5-13-2015, and a discharge date of 5-27-2015. Diagnoses included, but were not limited to, malignant neoplasm of bladder, hypertension, and cystostomy.</p> <p>Admission orders from (local hospital), dated 5-13-2015, indicated, "Apply urostomy one piece to skin making sure it is flush with the skin...Change every 3-5 days....) There was no documentation to indicate the orders from the hospital had been transcribed to the facility physician order records.</p> <p>Resident #B's care plans showed no documentation of a care plan related to urostomy care and assessment.</p> <p>Nurses notes for Resident #B indicated no documentation of a urostomy bag change.</p> <p>On 7-24-2015 at 8:00 A.M., the DON (Director of Nursing) indicated, "...orders for urostomy care should be obtained from the physician if they are not admitted with an order...we do not have a policy for urostomy care...."</p> <p>This deficiency relates to Complaint</p>			

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F 0309 SS=D Bldg. 00	<p>#IN00175535.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to document the assessment and monitoring per physician order of a resident receiving dialysis for 1 of 1 residents reviewed for dialysis. (Resident #18)</p> <p>Finding includes:</p> <p>On 7-22-15 at 12:48 P.M., the clinical record for Resident #18 was reviewed. Resident #18 was admitted, on 6-14-2012, with diagnoses including but not limited to renal failure, hypertension, end stage renal disease and diabetes mellitus type 2.</p>	F 0309	<p>Corrective action for resident # 18 cannot be accomplished. All residents receiving hemodialysis have the potential to be affected by the deficient practice. Residents who may potentially be affected by the deficient practice are identified when order is received for hemodialysis. Licensed nurses will be educated on Dialysis Guideline Policy including checking dialysis fistula for thrill by feeling fistula and for bruit by listening to fistula q shift. Nursing to notify physician for absence of thrill or bruit. Licensed nurses will be educated to document assessment of dialysis fistula on TAR daily. Director of Nursing or Designee will audit TAR of residents receiving</p>	08/23/2015

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	<p>A physician order, dated 8-22-2014, indicated "Assess dialysis graft site every shift and record (+) [positive] or absence (-) [negative] of thrill and bruit...."</p> <p>The Treatment Administration Record for May, June and July of 2015, indicated missing documentation on the following dates and shifts:</p> <p>5-4: evening shift 5-5: evening shift 5-6: day shift 5-8: evening and night shift 5-10: evening shift 5-11: day and evening shift 5-14: evening shift 5-18: evening shift 5-19: evening shift 5-20: day shift 5-25: evening shift 5-29: evening shift 5-30: day shift 6-1: evening shift 6-4: day shift 6-5: day shift 6-8: day shift 6-12: evening shift 6-15: night shift 6-19: evening and night shift 6-26: day shift 6-30: day shift 7-2: night shift 7-3: night shift 7-5: night shift</p>		<p>hemodialysis for fistula assessment 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>		

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	<p>7-7: night shift 7-9: night shift 7-10: night shift 7-14: evening shift</p> <p>On 7-22-15 at 1:30 P.M., an interview was conducted with RN (Registered Nurse) #7. RN #7 indicated the staff is to check the fistula every shift and document it on the TAR (Treatment Administration Record).</p> <p>On 7-22-15 at 1:50 P.M., an interview was conducted with the DON (Director of Nursing). The DON indicated the floor nurse would be expected to check the fistula per physicians order and document the assessment on the TAR.</p> <p>On 7-23-15 at 8:45 A.M., review of the current "Dialysis Guideline" policy, last revised 2013, received from the DON at this time, indicated "... Post Dialysis Protocol:...Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula)...Documentation on Treatment Sheets includes:...fistula checks...."</p> <p>3.1-37(a)</p>			

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F 0314 SS=D Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interviews, the facility failed to ensure preventative measures were implemented timely to prevent pressure ulcer development for 1 of 3 residents reviewed for pressure ulcers. (Resident #65) In addition, the facility failed to ensure a thorough, accurate assessment of pressure areas was completed for 1 of 3 residents reviewed for pressure ulcers. (Resident #76)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #65 was reviewed on 07/23/15 at 10:10 A.M. Resident #65 was admitted to the facility, on 03/09/15, with diagnoses, including but not limited to, end stage renal disease, osteoporosis, hypertension, wheezing, pain, status post fracture hip repair and abnormal gait.</p>			F 0314	<p>Corrective action for resident #65 cannot be accomplished as resident has been discharged from the living center. Corrective action for resident #76 cannot be accomplished as resident has been discharged from the living center. All residents have the potential to be affected by the deficient practice. Licensed nurses will be educated on implementing preventive measures to prevent pressure ulcer development. Licensed nurses will be educated on requirement to document a thorough, accurate assessment of pressure ulcers weekly. Residents were assessed for pressure ulcers. Pressure ulcer prevention measures have been implemented for residents at risk for pressure ulcers. Interdisciplinary team (IDT) will audit care plans for all newly admitted residents within 9 days of admission to ensure accurate</p>		08/23/2015

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	<p>The admission nursing assessment, completed on 03/09/15, indicated she did not have any pressure ulcers when she was admitted. Her admission physician's orders included a protective ointment to be applied to her buttocks due to her bowel and bladder incontinence.</p> <p>A Braden Scale for Predicting Pressure Sore Risk, also completed on 03/09/15, indicated the resident was at risk for pressure ulcer development due to being chair fast with limited mobility and potential issues with friction and shear.</p> <p>There was no care plan related to her at risk for pressure ulcer status initiated until 03/17/15, which indicated the resident had developed a pressure ulcer.</p> <p>A nursing progress note, dated 03/17/15 at 1:49 P.M., indicated the resident had a 6.1 cm (centimeter) by 5.4 cm by .1 cm shearing wound to her coccyx. The wound had a dark purple sheared wound base with 50 % of the edges light pink. The physician was notified and orders were received for hydrogel and mepifoam dressing and a cushion in her wheelchair.</p> <p>A nursing progress note, dated 03/21/15 at 10:22 P.M., indicated the resident's wound was now an odorous stage 3 (full tissue thickness loss) wound with a large</p>		<p>and complete care plan has been developed to include but not limited to treatment/care of any pressure ulcer for 6 months. Interdisciplinary team (IDT) will audit care plans for all newly admitted residents within 9 days of admission to ensure accurate and complete care plan has been developed to include but not limited to preventing pressure ulcer development for residents identified to be at risk to develop pressure ulcers. Director of Nursing of Designee will audit residents with newly acquired pressure ulcers to ensure thorough and accurate assessment of pressure ulcer is documented weekly. treatment is appropriate, and care plan is developed for all pressure ulcers weekly for 6 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>	

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	<p>amount of serosanguanous drainage.</p> <p>A therapy note, dated 03/16/15, indicated due to the resident's poor sitting tolerance a reclining back wheelchair and cushion for the resident's wheelchair was recommended by the therapist.</p> <p>A Weekly Pressure Ulcer Record form, located in the closed clinical record indicated on 03/18/15, a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed with slough) pressure ulcer was located on the resident's coccyx. The form indicated the wound was 6.1 cm by 5.4 cm by .1 cm in size and the wound bed was dark purple. The preventative measures/progress indicated the resident was to be turned every 2 hours had a pressure relieving mattress, and received a multivitamin.</p> <p>A Weekly Pressure Ulcer Record, provided by the DON on 07/23/15 at 11:00 A.M., initiated on 03/18/15 indicated a Stage 2 pressure ulcer 6.1 by 5.4 by .1 cm with no exudate had developed on the resident's coccyx. The form documented the preventative measures as turning every 2 hours, mattress, wheelchair cushion, cushion to dialysis, assist with transfers per care guide. The interventions had been</p>			

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	<p>altered from the original Weekly Pressure Ulcer Record located in the closed record provided on 07/21/15.</p> <p>During an interview with the DON on 07/24/2015 8:58:41 AM indicated she did not find any initial care plans for Resident #65 to address the resident's risk for pressure ulcer development.</p> <p>2. The clinical record for Resident #76 was reviewed on 07/23/2015 at 9:39 A.M. Resident #76 was admitted to the facility , on 05/11/15, with diagnoses, including but not limited to: acute renal failure, hyponatremia, anemia, depressive disorder, obstructive sleep apnea, heart failure, chronic venous hypertension, chronic airway obstruction, psoriasis, encephalopathy, and hematuria.</p> <p>The admission nursing assessment, completed on 05/11/15, indicated the resident was admitted with two stage one (Intact skin with nonblanchable redness of a localized area) red areas on the right and left crease in his upper buttocks/lower back area. The documentation did not measure the wounds but indicated they were due to "friction."</p> <p>A physician's order was obtained on 05/11/15 for "Lantiseptic Skin Protectant</p>			

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	<p>Ointment 50% Apply to gluteal creases topically every shift for redness to gluteal fold."</p> <p>The care plans, initiated on 05/16/15, indicated the resident had a physical functioning deficit and his skin was to be inspected with care and reddened or open areas were to be reported to the charge nurse.</p> <p>Another plan, initiated on 05/23/15, for a an altered skin integrity non pressure related to Excoriation. The goal was for the affected areas to heal without complications. The interventions were to conduct weekly skin inspection, skin assessments to be completed per living center policy, and treatments as ordered.</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 05/18/15, indicated the resident had two stage one pressure ulcers.</p> <p>The 14 day Medicare MDS, dated 05/25/15, indicated the resident was not marked as having any pressure ulcers.</p> <p>The wound documentation, located by the Director of Nursing on 07/23/2015 at 11:06 A.M. , indicated on 05/16/15, a 2.0 cm by 1.0 cm blanchable area was noted on the resident's coccyx. The form</p>			

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F 0318 SS=D Bldg. 00	<p>indicated the area had been incorrectly identified as a stage one pressure ulcer on the admission. During an interview with the DON, on 07/23/15 at 11:06 A.M., regarding why the area identified on the 05/16/15 form did not match the two areas identified on the admission record, . she indicated she was not aware of the issue and she could not ask the nurse who had completed the assessment because she was no longer employed by the facility.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p>			

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	<p>Based on observation, record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for range of motion limitations received services to maintain and/or improve his limitations. (Resident #34)</p> <p>Finding includes:</p> <p>On 07/22/2015 at 11:43 A.M., Resident #34 sat in his wheelchair in his room. The resident's back was kyphotic and he slumped to the right side in his wheelchair. His legs were crossed and bent at the knees. He was holding his head in his hands. Both his hands and head were located just above the right wheelchair armrest.</p> <p>The 06/21/15 quarterly Minimum Data Set (MDS) assessment indicated Resident #34 had no range of motion limitations.</p> <p>During an interview on 07/23/2015 at 2:13 P.M., LPN #20 indicated the resident's knees were contracted as he kept one knee extended and the other knee bent. She could not locate any care plan regarding any interventions to provide range of motion services for the resident or any specific care of his lower extremity contracture's.</p>	F 0318	<p>Corrective action for resident # 34 has been accomplished by providing range of motion to lower extremities including 15 repetitions to lower extremities on day and evening shift each day. The care plan and CNA care guide have been reviewed and revised to indicate this. All residents have the potential to be affected by the deficient practice. Nursing staff will be educated regarding requirement to provide treatment/services to increase range of motion or to prevent further decrease in range of motion to any resident with limited range of motion. Assessments have been reviewed for accuracy. Director of Nursing or Designee will audit initial assessment of newly admitted residents to ensure comprehensive, accurate, standardized, reproducible initial assessment of resident's functional capacity including but not limited to limited range of motion is documented, treatment/services provided and care planned to increase range of motion or prevent further decrease in range of motion 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Director of Nursing or Designee will audit periodic assessments to ensure accurate, standardized, reproducible assessment of resident's functional capacity including but not limited to limited range of motion is documented, treatment/services provided and</p>	08/23/2015			

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	<p>During an interview on 07/24/15 at 10:00 A.M. the Director of Nursing (DON) indicated Resident #34's left knee was contracted. She did not know how contracted or how limited his range of motion was in the affected knee.</p> <p>During an interview on 07/24/15 at 10:25 A.M., the DON indicated she had located a care plan regarding the resident's left leg contracture. The plan indicated ROM (range of motion) was to be monitored daily. When queried as to whether the resident received ROM services to his lower extremities she indicated the plan only said to monitor and she was not sure the resident received ROM. An interventions to provide passive Range of Motion exercises was not initiated until 07/24/15.</p> <p>When asked for any recent assessment of the extent of his contracture, the DON indicated therapy "screened" the resident quarterly for any needs. She was not aware of when the last evaluation regarding his contracture.</p> <p>During an interview on 07/24/15 at 10:43 A.M. the DON indicated she did not know when the resident had developed a contracture of his left leg and there was no policy and procedure to ensure residents with contracture's received</p>		<p>care planned to increase range of motion or prevent further decrease in range of motion 5 assessments weekly for 4 weeks; 3 assessments weekly for 4 weeks; 1 assessment weekly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient</p>	

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	services to prevent an increase in their contracture's. In addition, it was unclear why the resident had not received any range of motion for his upper extremity contracture's.  3.1-42(a)(2)			
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to implement a fall precautions for 1 of 3 reviewed for falls. (Resident #152)  B. Based on observation, interview and record review, the facility failed to keep a hazardous chemical locked in 1 of 2 storage/shower rooms. (200 south hall)	F 0323	Corrective action for resident # 152 has been accomplished by reviewing and revising resident's care plan. Corrective action for residents in rooms 103,104,107,108, 109, 112, 113,114, 115, 116,117,119,120,122, 123, 124, 127, 129, 130,131, 135, 206, and 218 has been accomplished by removing power extension cords and contacting a licensed	08/23/2015

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	<p>C. Based on observation, interview, and record review, the facility failed to ensure power extension strips were properly used in multiple rooms, which had the potential to affect residents in 24 of 68 resident rooms. (Rooms #: 103, 104, 107, 108, 109, 112, 113, 114, 115, 116, 117, 119,120,122, 123, 124, 127, 129, 130,131,135, 206, 217 and 218).</p> <p>Finding includes:</p> <p>A. During a staff interview on 7-21-2015 at 3:00 P.M., LPN (Licensed Practical Nurse) #8 indicated, "[Resident #152's name] has fallen 2 times since her admission 11 days ago...."</p> <p>An observation of Resident #152's room, on 7-21-2015 at 3:07 P.M., indicated a bed alarm and wheelchair alarm. Resident #152 indicated she was at the facility for rehab after falling and fracturing her right hip.</p> <p>A record review of Resident #152 on 7-23-2015 at 10 A.M., indicated diagnosis were, but not limited to, right hip fracture S/P (status post-after) ORIF (Open Reduction Internal Fixation), altered mental status, chronic pain syndrome, history of CVA (Cerebral</p>		<p>electrician to install additional electrical outlets as needed. Rooms in which power extension cords are being utilized until the licensed electrician installs additional outlets will be the rooms in which the outlets are installed as a first priority. No high amp usage equipment will be plugged into a power extension cord. Corrective action for residents with the potential to be affected by hazardous chemicals stored in common area has been accomplished by obtaining locking cabinets for all shower/storage rooms in which chemicals will be placed and secured when not in use. All residents have to potential to be affected by the deficient practice. Staff in all departments will be educated on requirement to ensure environment remains free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents to include but not limited to storage of hazardous chemicals in locked cabinets while not in use. Staff in all departments will be educated on requirement to ensure environment remains free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents to include but not limited to the use of power</p>				

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	<p>Vascular Accident).</p> <p>On 7-23-2015 at 2:08 P.M., Resident #152's room was observed to have no eye beam in the bathroom doorway. Two socks, a plastic cup lid and a Styrofoam cup and straw were on the floor. The phone cord and the call light cord were on the floor in between the bed and the residents wheelchair and the bed was not in the lowest position. A reacher was not seen in the residents room.</p> <p>On 7-23-2015 at 2:45 P.M., LPN (Licensed Practical Nurse) #2 indicated, "...I put an intervention of an eye beam in the bathroom doorway...I guess I forgot to let maintenance know to place it...."</p> <p>On 7-24-2014 at 10:00 A.M., care plans for Resident #152 for falls indicated, "...date initiated 07/15/2015, call light or personal items available and in easy reach or provide reacher...date initiated 07/19/2015...place eye beam on bathroom door when obtained...."</p> <p>On 7-24-2015 at 12:30 P.M., a review of the Verification of Investigation for Resident #152, dated 07/15/2015 23:15 (11:15 P.M.), indicated, "...Resident was ambulating in room without assistance...contributing factors...confusion and lack of awareness</p>		<p>extension cords and the installation of additional electrical outlets as needed by licensed electrician. Licensed nurses will be educated on Falls Management Guideline including but not limited to implementing appropriate intervention after falls and care planning of fall interventions. Nursing staff will be educated on requirement to utilize CNA care guides which indicate specific fall prevention interventions. IDT will audit resident falls to include but not limited to the implementation of appropriate intervention and that care plan is updated appropriately 5xweek for 4 weeks; 3xweek for 4 weeks; 1x week for 4 months. Executive Director of Designee will audit storage of hazardous chemicals in locked cabinet while not in use on both units to include audits on day shift, evening shift, and night shift 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Executive Director or Designee will audit use of power extension cords in all rooms weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice</p>	

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	<p>of surroundings...care plan revised: No...."</p> <p>On 7-24-2015 at 12:30 P.M., record review of the Verification of Investigation for Resident #152, dated 07/19/2015 at 10:30 A.M., indicated, "...Heard bathroom light on and when this writer went in to room observed resident on hands and knees on bathroom floor...place eye beam on bathroom door when obtained...."</p> <p>On 7-24-2015 at 8:55 A.M., the DON (Director of Nursing) provided the Falls Management Guideline, effective date 01/22/2015, and indicated the guidelines were the ones currently used by the facility. The guidelines indicated, "Following a resident's fall: Appropriate interventions are implemented...."</p> <p>B. On 7/20/2015 at 11:02 A.M. during an initial facility tour the 200 hall south shower room had an unlocked cabinet with a spray bottle full of liquid labeled Quat sanitizer. The cabinet had a posted sign on the door that indicated to keep cabinet locked at all times.</p> <p>On 7/20/2015 at 11:13, an interview with CNA # 9 indicated the shower room cabinet should be locked at all times when the room was not in use.</p>		has been accomplished.	

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	<p>No policy regarding the safe storage of chemicals was received from the facility.</p> <p>C. On 7/20/2015 at 11:26 A.M., during the initial facility tour, an extension power strip was noted in room 218-2, plugged into the wall with the residents bed, air mattress, and the resident's G-tube (Gastrostomy tube) feed delivery pack. The power strip was not affixed to the wall and was laying under the bed.</p> <p>On 7/23/2015 at 2:32 P.M., an interview with Employee #16, indicated most rooms have power strips that are free laying and not affixed to walls. Employee # 16 indicated multiple types of electrically powered equipment were plugged into the power strips, and equipment that required high amounts of electric should not be plugged in to power strips. A list of rooms that utilize unsecured power strips was provide by the facility. The list include room numbers: 103, 104, 107, 108, 109, 112, 113, 114, 115, 116, 117, 119,120,122, 123, 124, 127, 129, 130,131,135, 206, 217 and 218.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F 0328 SS=D Bldg. 00	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>A. Based on interview and record review, the facility failed to provide proper care of a urostomy for 1 of 3 residents reviewed for ostomies. (Resident #B)</p> <p>B. Based on observation and interview, the facility failed to ensure nebulizer treatment equipment was cleaned and stored in a sanitary manner. This deficiency affected 1 residents of 3 residents observed for nebulizer use. (Resident #106)</p> <p>Finding includes:</p> <p>A. On 7-22-2015 at 1:08 P.M., a record review for Resident #B indicated an</p>	F 0328	<p>Corrective action for resident #B is unable to be accomplished as resident has been discharged from living center. All residents have the potential to be affected by the deficient practice. Licensed nurses to be educated on requirement to ensure residents receive proper treatment and care for special services: injections, parenteral/enteral fluids, colostomy, ureterostomy or ileostomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prosthesis. Licensed nurses will be educated on order transcription. Admission orders will be verified by a second licensed nurse upon admission before orders are communicated to pharmacy. All physician orders</p>	08/23/2015

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	<p>admission date of 5-13-2015 and a discharge date of 5-27-2015. Diagnoses included, but were not limited to, malignant neoplasm of bladder, hypertension, and cystostomy. The MDS (Minimum Data Set-an assessment) indicated BIMS (Brief Interview for Mental Status-an assessment) was 13/15, indicating no cognitive deficits.</p> <p>Admission orders from (local hospital), dated 5-13-2015, indicated, "...Apply urostomy one piece to skin making sure it is flush with the skin...Change every 3-5 days....)</p> <p>Physicians orders from the facility showed no documentation of an order to change the urostomy bag. Resident #B's care plans showed no documentation of a care plan related to urostomy care and assessment.</p> <p>Nurses notes for Resident #B indicated no documentation of a urostomy bag change.</p> <p>On 7-24-2015 at 8:00 A.M., the DON (Director of Nursing) indicated, "...orders for urostomy care should be obtained from the physician if they are not admitted with an order...we do not have a policy for urostomy care...."</p>		<p>have been verified. Licensed nurses will be educated on Medication Administration Nebulizer Policy and Procedure to include by not limited to rinsing medication reservoir and mask after administration is completed and drying before being placed in plastic bag, changing mask and tubing weekly. Director of Nursing or Designee will audit hospital physician orders and ensure accuracy of transcription of admission orders 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. IDT will audit care plans for all newly admitted residents within 9 days of admission to ensure accurate and complete care plan has been developed for 6 months. Director of Nursing or Designee will audit administration of nebulizer treatments on both units including audits for day shift , evening shift, and night shift to include but not limited to rinsing of medication reservoir and mask, allowing to air dry before placing in plastic bag for storage 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>				

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	<p>B. On 7/23/15 at 10:48 A.M., LPN #1 was observed completing a nebulizer treatment for Resident #106. When the treatment was complete LPN #1 placed the treatment mask in a plastic bag without cleansing out the medication reservoir or treatment mask.</p> <p>During an interview, on 7/23/15 at 11:56 A.M., LPN #1 indicated after a nebulizer treatment the nurse should put the treatment mask, with medication reservoir, in a plastic bag.</p> <p>On 7/23/15 at 1:30 P.M., the Director of Nursing (DON) provided a policy titled "Medication Administration Nebulizer's," dated 10/07, and indicated the policy was the one currently used by the facility. The policy indicated "... 11. Turn off the compressor. Disconnect the nebulizer reservoir from compressor. Clean the nebulizer per manufacturer's instruction...."</p> <p>During an interview, on 7/23/15 at 1:45 P.M., the DON indicated there was no policy regarding the cleansing of the mask or medication reservoir. The DON further indicated the expectation would be to rinse the medication reservoir and mask out with water and place on paper</p>			

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F 0333 SS=D Bldg. 00	<p>towel to dry and place in plastic bag. The DON indicated the mask, tubing and reservoir are changed of weekly.</p> <p>This deficiency relates to Complaint #IN00175535.</p> <p>3.1-47(a)(3) 3.1-47(a)(6)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interviews, the facility failed to ensure the physician's orders were followed regarding medications and failed to ensure a significant medication error did not occur related to blood pressure medication being omitted and dose thyroid medication transcribed wrong for 1 of 3 residents reviewed for hospitalization.</p>	F 0333	<p>Corrective action for resident #39 included reviewing hospital physician's orders for readmission to living center and verifying these orders with attending physician at living center. All residents have the potential to be affected by the deficient practice. Licensed nurses will be educated on order transcription. Admission orders will be verified by a second license nurse upon admission</p>	08/23/2015

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	<p>(Resident #39)</p> <p>Finding includes:</p> <p>The clinical record for Resident #39 was reviewed on 07/22/15 at 2:35 P.M. Resident #39 was admitted to the facility on 05/22/15, with diagnoses, including but not limited to, sepsis, hypothyroidism, diabetes, acidosis, dementia, generalized anxiety disorder, hypertension, atrial fibrillation, acute cholecystitis and chronic kidney disease.</p> <p>The physician's orders for medications, noted on the 05/22/15, acute care center's transfer documentation, indicated the resident was to continue to receive Metoprolol (a blood pressure and heart medication) 50 mg (milligrams) every 12 hours and Levothyroxine .175 mg one tablet once a day.</p> <p>The facility "order summary report," completed on 05/22/15, indicated the Metoprolol medication was omitted from the order report and the Levothyroxine dose was documented as "75 mcg [microgram]" instead of .175 mg.</p> <p>The May 2015 and the June 2015 Medication Administration Records confirmed the Metoprolol was not administered to Resident #39 as ordered</p>		<p>before orders are communicated to pharmacy. Physician orders have been verified for all residents. Director of Nursing or Designee will audit hospital physician orders and ensure accuracy of admission orders 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>		

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	<p>and the incorrect dose of 75 mcg of Levothyroxine medication was administered to Resident #39.</p> <p>An acute care History and Physical report, dated 06/19/15, indicated Resident #39 was readmitted to the acute care facility due to shortness of breath and an elevated heart rate. The resident's heart rate on arrival was 172 beats per minute. She was also diagnosed with acute respiratory insufficiency, suspected congestive heart failure exacerbation, atrial fibrillation in rapid ventricular rate and an elevated TSH level (thyroid stimulating hormone).</p> <p>Interview with LPN #20 on 07/22/15 at 2:45 P.M. confirmed the transfer orders from the acute care center for Resident #39 did not match the transcribed order summary report. She confirmed there was no Metoprolol and the Levothyroxine dose did not match.</p> <p>3.1-25(b)</p>			

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F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>A. Based on observation, interview and record review, the facility failed to store, prepare and serve food in a sanitary manner related to storage of dry good and pans, undated items, hairnet use, cleaning equipment, hairnet use and handwashing in 1 of 1 kitchens and 1 of 2 dining rooms. (Main Dining Room)</p> <p>B. Based on observation, interview and record review, the facility failed to test and record the strength of the sanitizing solution for the 3 compartment sink in 1 of 1 kitchens.</p> <p>Findings include:</p> <p>A.1. On 7/20/15 between 10:35 A.M.,and 11:30 A.M., an initial kitchen tour was conducted with the DM (Dietary Manager). The following was observed:</p> <p>At 10:40 A.M., bulk storage containers</p>	F 0371	<p>Corrective action will be accomplished for all residents who may potentially be affected by the deficient practice by reeducating staff on storage, preparation, and distribution of food under sanitary conditions. All residents have the potential to be affected by the deficient practice. Dietary staff will be educated on proper labeling, dating, storage of food items in refrigerator, freezer, and dry storage, storage of bulk items, storage of dishes, personal belonging in kitchen, food items and ice are properly covered, proper wearing of hairnets, proper washing of dishes, and sanitizing solutions with the three compartment sink being completed according to facility policy. Staff are being trained not only on how to successfully complete the items but also on how to properly document completion of corresponding logs as applicable. Nursing staff will be educated on proper handling of dishes, handwashing, and no</p>	08/23/2015

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	<p>containing sugar, graham cracker crumbs, and flour were all observed to have scoops laying in them. At this time Dietary Aide #11 indicated " No those should not be in there."</p> <p>At 10:42 A.M., in the cabinet below the prep area: An employees purse stored next to the cookie sheets. 2 stock pans stored upright. The DM indicated "... that purse should not be there and the pans should be stored inverted..."</p> <p>At 10:45 A.M., in the walk in cooler: 24-undated, glasses of ice tea, 1- undated, glass of lemonade, 3- undated, pitchers of ice tea, 2- undated, pitchers of lemonade, 6-undated, pitchers of orange juice, 2- undated pitchers of apple juice, and 1- undated pitcher of ice tea. The DM indicated at this time "... yes they should be dated...."</p> <p>2 open uncovered large igloo coolers with ice. The DM indicated at this time "... yes those should be covered...."</p> <p>11:00 A.M., in the walk in freezer: 19 carafes of ice water, uncovered and undated, 5- undated pitchers lemonade, open, undated bag of sweet potato's, open, undated bag of cauliflower, box of frozen cookies open to air, 7 - undated, individual wrapped pieces of cake. The DM indicated at this time "...everything</p>		<p>bare hand contact of food. Dietary Manager or Designee will audit proper labeling, dating, storage of food items in refrigerator, freezer, and dry storage, storage of bulk items, storage of dishes, personal belonging in kitchen, food items and ice are properly covered, proper wearing of hairnets, proper washing of dishes, and sanitizing solutions with the three compartment sink being completed according to facility policy 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. Dietary Manager, Executive Director, Corporate Registered Dietician, or their Designees will audit proper handling of dishes, handwashing, and no bare hand contact of food including audits of breakfast, lunch, and dinner 5xweek for 4 weeks; 3xweek for 4 weeks; 1xweek for 4 months. The corporate Registered Dietician and or the Executive Director (or their designees) will make weekly rounds of the kitchen and storeroom for 90 days to monitor cleanliness. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>		

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	<p>in here that is open should be covered and dated...."</p> <p>11:15 A.M., Dietary aide #12 was observed with hair hanging out of back of her hairnet.</p> <p>On 7/22/15 at 2:00 P.M., review of the current undated policies titled " Storing Dried Food, Storage of Frozen Foods, Storage of Refrigerated Foods, Infection Control-Dining Services Employee Hair Guidelines, Pot and Pan Washing and Sanitation," provided by the Executive Director, indicated "... Storage of Bulk Items...Do not store scoops in bins or product...Opened Packages: Properly reseal packages of frozen foods that have been opened to prevent freezer burn...Freezing Extra Portions... all items must be labeled with specific product name, date frozen and use by date...must be labeled and noted with use by date... Hairnets ...must cover all hair completely...6. Inspect and store pots and pans inverted in a clean dry protected area."</p> <p>A. 2. On 7/23/15 at 4:00 P.M.,during pureed meal preparation Dietary Aide #13 was observed to make pureed ham sandwiches, the DM placed all the dirty measuring spoons and cups in to a</p>			

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	<p>mixing bowl of hot water. Dietary Aide #13 was observed removing the measuring cup from the mixing bowl of dirty dishes, rinsing it under running water in sink then measure out diced tomatoes and place in puree machine. She then removed a measuring spoon from the mixing bowl of dirty dishes, rinsing it under running water in the sink, shook the excess water off, then measured out food thickener and placed it into he puree machine with the diced tomatoes and proceeded to puree the tomatoes for the dinner meal.</p> <p>During an interview on 7/23/15 at 9:50 A.M., the DM indicated "... she should have taken the bowls,measuring cups and spoons and ran it through the dishwasher before using them...."</p> <p>On 7/23/15 at 10:20 A.M., review of the undated policy " Pot and Pan Washing and Sanitation," provided by the DM as the current policy, indicated " ...1. Thoroughly wash using hot water... and detergent after food particles have been scraped...."</p> <p>A. 3. On 7/20/15 between 12:05 P.M., and 12:50 P.M., during the lunch meal in the Main Dining Room the following was observed:</p>			

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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	<p>At 12:16 P.M., LPN( Licensed Practical Nurse) #14 was observed washing her hands for 12 seconds, then served a lunch plate to a resident.</p> <p>At 12:19 P.M., CNA ( Certified Nursing Assistant) #6 was observed assisting to feed Resident #99, remove his cell phone from his scrub pocket, check it, place it back in his pocket, then continue to assist Resident #99 with his meal without washing his hands.</p> <p>At 12:20 P.M., LPN # 8 was observed washing her hands, turned off facet with a paper towel, dried hands with the same paper towel, then served a resident a lunch plate.</p> <p>At 12:24 P.M., CNA #6 was observed handing resident #99 a slice of bread with his bare hand.</p> <p>At 12:28 P.M., CNA #6 was observed picking up a piece of bread from Resident #99 lunch plate, handed it to resident with his bare hand, then got up and poured resident a glass of lemonade then continued to assist feeding resident without washing his hands.</p> <p>At 12:38 P.M., CNA #6 was observed handing resident #99 a slice of bread with his bare hand.</p>			

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	<p>At 12:47 P.M., CNA #15 was observed assisting feeding a resident then got up went to a different table and adjusted a residents lunch plate, then returned to continue assisting feeding her resident.</p> <p>On 7/22/15 between 11:50 A.M., and 12:30 P.M., during the lunch meal the following was observed:</p> <p>At 12:03 P.M., RN ( Registered Nurse ) #17 was observed washing her hands for 7 seconds then served a lunch plate to a resident with her thumb on the inside edge of the plate.</p> <p>At 12:21 P.M., RN # 17 was observed serving a lunch plate to a resident with her thumb on the inside edge of the plate.</p> <p>On 7/22/15 at 1:49 P.M., review of the current policy titled " Handling Clean Equipment and Utensils," dated 2/12/15 and the undated policy" Infection Control- Hand Washing," provided by the Executive Director, indicated " ...Handle clean cups, glasses and bowls so that fingers and thumbs do not contact the inside surfaces or lip contact surface... washing hands and rinsing exposed portions of arms ...vigorously for a minimum of 20 seconds...When to wash hands...before food handling, preparation</p>			

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	<p>or services... as often as necessary to remove soil and contamination and to prevent cross-contamination...."</p> <p>During an interview on 7/23/15 at 140 P.M., the DON (Director of Nursing) indicated "...CNA's that are assisting feeding residents should not be on their cell phones... they should wash their hands after touching a cell phone or a resident... they should never touch any food with their bare hands... staff should wash their hands for as long as it takes to sing happy birthday twice..."</p> <p>B.1. On 7/20/15 at 11:04 A.M., during the initial kitchen tour the Dietary Manager indicated " ... we do not have a log for the sanitizing solution strength for the 3 compartment sink ...we should be logging it ... the prep cook is responsible for logging the strength of the sanitizer in the sink...."</p> <p>On 7/22/15 at 1:49 P.M., review of the current undated policy " Pot and Pan Washing and Sanitation; Manual Warewashing and Sanitation," provided by the Executive Director, indicated "...</p> <p>3. Sanitizing solution: Test and record the strength of sanitizing solution...."</p> <p>3.1-21(i)(2)</p>			

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F 0431 SS=D Bldg. 00	<p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the</p>			

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	<p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were secured for 1 of 4 medication carts on B-wing hall.</p> <p>Finding includes:</p> <p>During initial tour on 7-20-2015, between 12:12 P.M. and 12:23 P.M., a medication cart on the B-wing hall was observed to be unlocked and unattended. Six residents, three family members and two housekeepers were observed to be in the halls during this time. LPN (Licensed Practical Nurse) #5 indicated the cart should be locked when not attended.</p> <p>On 7-24-2015, between 5:12 A.M. and 5:16 A.M., a medication cart was observed to be unlocked and unattended on the B-wing hall. One resident was observed to be mobile in her wheelchair, in the hall, during this time. LPN #5 indicated the cart should be locked when not attended.</p> <p>On 7-24-2015 at 8:00 A.M., the DON (Director of Nursing) indicated medication carts should be locked when not attended. A policy, "Medication Storage in the Facility", dated 05/12, received at this time from the DON,</p>	F 0431	<p>Corrective action for all residents who have the potential to be affected by the deficient practice has been accomplished by locking the medication cart while not in attendance of qualified employee. All residents have the potential to be affected by this deficient practice. Licensed nurses will be educated on requirement to ensure medications are secured while not in attendance of qualified employee including but not limited to Medication Storage in the Facility Policy, locking medication cart when not in attendance of qualified employee. Director of Nursing or Designee will audit storage of medication in the facility including but not limited to observing carts for secured medications on both units including audits on day shift, evening shift, and night shift 5xweek for 4 weeks, 3xweek for 4 weeks, 1xweek for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>	08/23/2015			

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F 0465 SS=D Bldg. 00	<p>indicated, "...Procedures...B...Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access."</p> <p>3.1-25(m)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure a clean environment was maintained related to a resident's dirty IV (intravenous) pole and the surrounding tiled floor for 1 of 30 rooms observed for cleanliness. (Resident #94)</p> <p>Findings include:</p> <p>On 7/20/2015 at 11:26 A.M., during an initial facility tour, Resident #94 was observed while receiving a continuous G-tube (gastrostomy tube) feed of Jevity High Protein Nutrition. The IV pole was covered with a white dried substance from the level of the hanging Jevity solution to the 4 rolling feet at the base of</p>	F 0465	<p>Corrective action for resident #94 was accomplished by cleaning IV pole and floor. All residents have the potential to be affected by this deficient practice. Staff in all departments will be educated on requirement to provide safe, functional, sanitary, comfortable environment including but not limited to cleaning of IV poles for enteral feedings and cleaning enteral feeding spills from floors, poles, and equipment. Executive Director or Designee will audit cleanliness of floor and equipment in all rooms weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement</p>	08/23/2015	

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	<p>the pole. The feet of the IV pole where covered in a dried light brown solution. There were multiple splatters of dried brown solution to the surrounding floor in a 3 foot diameter.</p> <p>On 7/21/2015 at 9:00 A.M., during an observation of Resident #94's IV pole and floor, a dried white substance from the level of the hanging Jevity solution to the 4 rolling feet at the base of the pole. The feet of the IV pole where covered in a dried light brown solution. There were multiple splatters of dried brown solution to the surrounding floor in a 3 foot diameter.</p> <p>On 7/22/2015 at 12:44 P.M., during an observation, Resident #94's pole remained soiled.</p> <p>On 7/23/2015 at 1:18 P.M., during an observation, Resident #94's pole remained soiled.</p> <p>On 7/24.2015 at 6:52 A.M., an interview with LPN #8 (Licence Practical Nurse), indicated she did not know who was responsible for cleaning the IV poles, but she would clean them with alcohol wipes if she would see one dirty.</p> <p>On 7/24/2015 at 7:00 A.M., an interview with CNA #8 (Certified Nursing</p>		(QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.		

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	<p>Assistant) indicated she did not know who was responsible for cleaning the IV poles, but that she does clean them if she sees they are dirty, and then she would notify housekeeping.</p> <p>On 7/24/2015 at 7:31 A.M., an interview with the DON (Director of Nursing), indicated the CNAs are responsible for cleaning the IV poles and housekeeping staff were responsible for cleaning floors.</p> <p>On 7/24/2015 at 12:20 P.M., the CNA cleaning schedule was provided by the DON and indicated the CNA would be responsible for cleaning IV and feeding pump poles.</p> <p>3.1-19(f)</p>			