

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 29, 30, 31, August 1 and 2, 2013</p> <p>Facility number: 000258 Provider number: 155367 AIM number: 100289160</p> <p>Survey team: Rita Mullen, RN, TC Sandra Nolder, RN Angela Selleck, RN Jason Mench, RN</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census payor type: Medicare: 4 Medicaid: 87 Other: 10 Total: 101</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley on August 12, 2013.</p>	F000000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The facility respectfully requests a desk review for paper compliance.	

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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F000156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure Liability and Benefit Coverage End Notices were provided to resident/family 48 hours prior to end of coverage for 2 of 4 residents reviewed for Medicare Non-Coverage Notices (Residents #'s 40 and 59).</p> <p>Findings include:</p> <p>Notice of Medicare Non-Coverage letters were reviewed on 8/2/13 at 10:30 a.m.</p> <p>1. Resident #40's family was notified by certified letter to Pennsylvania with a receipt of letter by family on 6/22/13 with Medicare coverage ending on 6/22/13.</p> <p>During an interview with the Minimum Data Set Coordinator on 8/2/13 at 10:30 a.m., she indicated the facility had called the family member for Resident #40 at home on 6/19/13 and explained to the family member Resident #40's Medicare Benefits were ending on 6/22/13 and they had papers for him to sign. Resident #40's family indicated he wanted them to send the letter to him in Pennsylvania. The facility could not</p>	F000156	<p>The facility contacted or attempted to contact both Resident #40 and resident #59's families 48 prior to end of coverage.</p> <p>All residents with Medicare coverage have the potential to be affected by the deficient practice.</p> <p>Facility will document time and date that phone calls are made to resident family members regarding Medicare end of coverage. Facility will verify attempted calls with 2 signatures rather than one signature. A log will be kept with this information in the business office.</p> <p>These logs will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	09/01/2013	

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	<p>provide any record of this phone converstation by time of exit.</p> <p>2. Resident #59 had Medicare coverage end on 5/28/13 with notice of Medicare Non-Coverage document signed on 5/28/13 by family. The facility attempted to call Resident #59's family on 5/23/13 and 5/24/13 with verification of attempts by only one employee signature.</p> <p>During an interview with MDS coordinator on 8/2/13 at 10:30 a.m., she indicated she did not think they were still required to have two signatures since there was only one signature line on the Notice of Medicare Non-Coverage form.</p> <p>3.1-4(a)</p>				

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F000241 SS=D	<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, record review and interview the facility failed to ensure residents were positioned at meal time in a manner that did not impair their ability to self feed for 2 of 4 residents observed during meal time (Residents # 121 and # 127) and failed to ensure personal dignity was maintained during toileting for 1 of 1 resident who voiced concerns during an interview. (Resident # 6)</p> <p>Findings include:</p> <p>1. During interview with Resident # 6 on 7/30/13 at 9:59 a.m., she stated, "When you are having a bowel movement they will go right outside your door and blurt it right out and they don't care who is around and it embarrasses you when they are talking about you out in front of everybody."</p> <p>A 6/3/13 quarterly MDS (Minimum Data Set) assessment for resident # 6 indicated the resident was cognitively intact, extensive assist of one person</p>	F000241	<p>All residents have the potential to be affected by the deficient practice. Adjustable height tables were ordered on 8/23/2013. Nursing staff in-serviced on resident dignity including ensuring personal dignity is maintained during toileting of a resident. Therapy staff observed all residents during dining to determine appropriateness of current seating arrangement facilitate resident comfort during meal service. Unit Manager/designee to conduct rounds and randomly ask residents if they have any concerns with staff maintaining their dignity when providing care. These rounds to be completed 5 times weekly x 30 days then 3 times weekly x 30 days, then weekly x 4 months. Any issues identified will be addressed at the time they are noted. Therapy staff to screen residents as needed during daily meals. Therapy department to perform Quarterly screens on all residents to determine if residents are sitting at tables in dining room with appropriate heights and communicate to interdisciplinary team during AM meeting. Results</p>	09/01/2013			

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	<p>for transfers, dressing, personal hygiene and toileting. The resident was also continent of bowel.</p> <p>During an interview with the Director of Nursing (DON) on 8/2/13 at 1:00 p.m., she indicated she expected the staff to show respect and dignity towards the residents. The DON indicated she would have the Director of Clinical Education do education on dignity for the staff.</p> <p>2. During a lunch observation on 7/31/13 at 11:45 a.m., in the Main Dining Room, Resident #127 was noted to be seated at a dining table with a height that came to the resident's neck level.</p> <p>During an interview with Resident #127 on 7/31/13 at 12:02 p.m., she indicated the table was too high and she had to stretch her arms up to reach for items on the table.</p> <p>3. During a lunch observation on 7/31/13 at 11:45 a.m., in the Main Dining Room, Resident #121 was noted to be seated at a dining table with a height that came to the resident's neck level.</p> <p>During an interview with Resident #121 on 7/31/13 at 12:12 p.m., she indicated the table was too high and</p>		<p>of these rounds and screens to be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>				

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	<p>stated "...I'm paralyzed on my left side...it is already hard for me to cut up my food...."</p> <p>During an interview with the Administer on 8/2/13 at 1:08 p.m., he indicated he was unaware the tables in the Main Dining Room were too high for resident comfort.</p> <p>3.1-3(t)</p>			

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F000244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on record review and interview, the facility failed to resolve the resident council concerns and update the resident council on the progress of the concerns. This deficit practice had the potential to impact 101 of 101 residents residing in the building.</p> <p>Findings include:</p> <p>Resident council minutes were provided for review by the Administrator on 8/1/13 at 10 a.m.</p> <p>Resident council minutes on the following dates and times indicated:</p> <p>January 2013: 6 of 6 residents had a concern regarding beds not made in a reasonable time frame and 4 of 6 residents had concerns with Certified Nursing Assistants (CNA's) who answered call lights and were told they were not that CNA's "patient"</p> <p>March 2013: 6 of 6 residents had</p>	F000244	All residents have the potential to be affected by the deficient practice. Activity staff in-serviced on Golden Living Resident Council Process including follow-up with resident concerns and communication to Executive Director. Resident council will be held weekly x 4 weeks then biweekly for 2 months (monthly thereafter). Executive Director/designee will attend these meetings to ensure concerns are heard. Any concerns will be documented on individual grievance forms or Department Response Forms and followed up on by the next meeting. The meeting notes and results will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.	09/01/2013	

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	<p>concerns regarding CNA's that answered call lights and 0 of 6 residents agreed the administrator listened to their suggestions.</p> <p>April 2013: 8 of 10 residents had concerns with CNA's that answered call lights. The concern regarding the beds not made in a reasonable time frame was brought up to the council by residents.</p> <p>June 2013: 4 of 9 residents had concerns regarding CNA's that answered call lights and they indicated they would come back, but never returned and 6 of 9 residents agreed the Administer listened to their suggestions.</p> <p>July 2013: 4 of 10 residents had concerns regarding they were not able to get timely assistance during the midnight shift. Recommendations for guests or topic of information for the next resident council meeting was to invite the nursing staff to attend.</p> <p>During an interview with Resident # 20 he indicated the Activity Director would write down the resident council members suggestions and concerns and take them to the Administrator. Resident # 20 indicated the Administrator was suppose to review</p>						

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	<p>the suggestions and concerns then let the council members know what the Administrator decided, but he indicated he had not heard from the Administrator.</p> <p>During the interview with the Administrator on 8/2/13 at 1:08 p.m., he indicated he addressed resident's concerns by having the Social Service Specialist write the concerns up and bring them to him. He then indicated depending on the nature of the concern, the concern would be given to the appropriate person to investigate and follow-up with the resident who had the concern.</p> <p>An undated policy titled "Golden Living Centers Resident Council Process" was provided by the Activity Director on 8/2/13 at 2:10 p.m., and deemed as current. The policy indicated council issues will be handled "if one resident has an issue, it is an individual grievance. If two or more residents have issues, the Department Response Form (DRF) is to be utilized...The DRF's...At the next Council Meeting the residents will decide whether the issue has been resolved (at least all but one resident agree)...Council concerns also get added to the QA [Quality Assurance] minutes."</p>				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to track a resident's disruptive behaviors for 1 of 1 resident reviewed for behaviors (Resident #41)</p> <p>Findings include:</p> <p>The clinical record of Resident #41 was reviewed on 8/1/13 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, diabetes, anemia in chronic kidney disease, venous insufficiency, edema, insomnia, depression, reflux, hypothyroidism, renal failure, osteoarthritis, obesity, constipation, anxiety and narcissistic personality disorder.</p> <p>A Care Plan indicated "Resident makes false statements about staff and family. She is attention seeking and will say whatever(true or not) to draw attention to self. History of misinterpreting conversations with others as she appears to understand, but will then turn the story around and have several versions of the same</p>	F000250	<p>Resident #41 care plan was reviewed and updated.</p> <p>Social Services Specialist reviewed Behavior Monitoring Logs at nurses stations and CareTracker to identify any other residents exhibiting behaviors with interventions updated as needed.</p> <p>Nursing staff in-serviced on use of Behavior Monitoring Logs to record any behaviors by residents. Social Services Specialist to review logs as well as Care Tracker report for residents exhibiting behaviors and provide an intervention for any resident on this report per resident's plan of care. Behavior Monitoring Logs will be audited 5 times weekly x 60 days, 3 times weekly x 60 days, then 2 times weekly thereafter.</p>	09/01/2013			

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	<p>event." Interventions included, but not limited to, ask resident specific information...come up with resolution to everyone's acceptance and follow-up with resident to assure concern is resolved.</p> <p>A Behavior Monthly Flow Sheet, for the month of July 2013, indicated the psychoactive medications and the episodes of anxiety, depression and insomnia. Specific behaviors were not addressed.</p> <p>A Quarterly Interdepartmental Team meeting note, dated 4/11/13 indicated behavior symptoms of socially inappropriate/disruptive.</p> <p>A Quarterly Interdepartmental Team meeting note, dated 7/9/13 indicated behavior symptoms of socially inappropriate/disruptive.</p> <p>During an interview with the Social Service Specialist, on 8/2/13 at 11:00 a.m., he indicated he only keeps track of the symptoms the medications are treating and not the behaviors.</p> <p>A Behavior Management Guideline, dated 12/2012, received from the Director of Nursing on 8/2/13 at 1:15 p.m., indicated the following:</p>		<p>Results of these audits to be reviewed at QAPI monthly times 6 months to track for any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>				

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	<p>"Purpose</p> <p>To develop behavior plans and medication regimes, when appropriate, to optimize the functional abilities of residents while monitoring for adverse side effects and improved behaviors....</p> <p>The antecedent Behavior Monitoring Log is utilized for new resident with behaviors and current residents who exhibit new behaviors that negatively impact functioning of quality of life....</p> <p>Based on a review of the tracking log, a determination will be made if the resident is a danger to self or others..."</p> <p>3.1-34(a)</p>				

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F000282 SS=D	<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 interview, the facility failed to ensure bowel movements were monitored for 2 of 10 residents reviewed for bowel movements in a sample of 10. (Resident # 13 and # 42)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident # 13's record was reviewed on 7/31/13 at 9:45 a.m. Her diagnoses included, but were not limited to, senile dementia uncomplicated, unspecified constipation, pain in joint site, and pathologic fracture of neck of femur. <p>Resident # 13's care plan dated 4/26/11 indicated she had a history of constipation and risk related to narcotic use with these interventions being used, and the goal for the resident was for her to have a bowel movement (BM) every third day with a target date of 10/29/13.</p> <ol style="list-style-type: none"> Administer colace, dulcolax suppository and milk of magnesia as ordered Encourage meal and fluid 	F000282	<p>Bowel tracking forms reviewed for Resident #13 and Resident #42 with interventions given as appropriate.</p> <p>Bowel tracking forms were reviewed for all residents for the past 30 days. Any resident identified to have been affected by the deficient practice had an abdominal assessment completed with interventions given as appropriate per plan of care.</p> <p>Nursing staff in-serviced on Bowel Management protocol which includes monitoring for bowel movements and recording them into Care Tracker system. Licensed nursing staff to review Care Tracker report for residents with no bowel movements for past 9 shifts and provide</p>	09/01/2013			

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	<p>consumption</p> <p>3. Encourage physical activity as tolerated</p> <p>4. Observe BM pattern</p> <p>Resident # 13's bowel movement (BM) record indicated she did not have a BM from 6/29/13 to 7/23/13 and 7/25/13 to 7/30/13. Resident had a BM on 7/24/13 and two BM's on 7/31/13.</p> <p>The physician's orders for July 2013 indicated the resident had an order for colace 100 milligrams two tablets daily. The original date of the order was 4/24/13 for a diagnosis of unspecified constipation. She also had an order for dulcolax suppository rectally as needed with an original date of 1/25/13 and milk of magnesia 30 milliliters by mouth as needed for constipation with an original order date of 1/25/13. The physician was notified of the resident's frequent constipation and new orders were given on 7/31/13 for a soap suds enema daily as needed and 8/1/13 for miralax daily.</p> <p>The Medication Administration Record (MAR) indicated Resident #13 had been administered MOM four times in the month of July on 7/22/13, 7/24/13, 7/28/13, and 7/29/13 all of</p>		<p>an intervention for any resident on this report per resident's plan of care. Unit Manager/designee to review this report to ensure appropriate interventions have been given for any resident on this list. These audits to be completed 5 times weekly x 60 days, 3 times weekly x 60 days, then 2 times weekly thereafter.</p> <p>Results of these audits to be reviewed at QAPI monthly times 6 months to track for any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>				

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	<p>which were documented as not effective. Dulcolax Suppository had been administered rectally two times once on 7/3/13 which was ineffective and on 7/31/13 was effective with two large BM's.</p> <p>During an interview on 7/31/13 at 3:10 p.m., the Alzheimer's Unit Manger indicated, Resident # 13 only had one BM this month on 7/24/13. She indicated a nurse went to do a bowel assessment on the resident this afternoon because she was not sure what is going on with this resident's abdomen.</p> <p>During an interview on 8/1/13 at 9:30 a.m., the Alzheimer's Unit Manager indicated, Resident # 13 had two large BM's last evening after she was administered a dulcolax suppository.</p> <p>During an interview on 8/1/13 at 2:05 p.m., CNA # 5 and CNA# 6 indicated when BM's are documented in the caretracker they have to answer yes or no as to whether they have or have not had a BM. They indicated they can not skip the question or leave it blank and if the answer to the question is answered as no then the resident did not have a BM.</p> <p>During an interview on 8/1/13 at 2:56</p>			

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	<p>p.m., with Alzheimer's Unit Manager indicated the facility did not have an official bowel protocol to follow.</p> <p>The "Bowel Management Policy and Protocol" was received from the DON on 8/2/13 at 8:35 a.m. The DON indicated the facility had not been following this bowel protocol, but the nursing consultant had sent it to her as a policy to be used as their bowel protocol.</p> <p>2. Record review for Resident # 42 was completed on 7/31/13 at 2:30 p.m. Diagnoses included, but were not limited to legal blindness, Osteoarthritis, and senile dementia with depressive features.</p> <p>Resident # 42's care plan started on 3/18/13 indicated she had occasional problems with constipation with these interventions. The goal for this resident was to have a BM at least every three days with a target date of 9/6/13.</p> <p>1. Cue and encourage resident to consume all or her fluids and nutrition as tolerated</p> <p>2. Give dulcolax, MOM</p> <p>3. Monitor BM pattern</p> <p>Resident # 42's bowel movement</p>						

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	<p>(BM) record indicated she did not have a BM from 7/21/13 to 7/28/13. Resident had a BM on 7/20/13 and 7/29/13.</p> <p>The physician's orders for July 2013 indicated the resident had an order for dulcolax suppository ten milligrams rectally daily as needed for constipation with an original start date of 8/23/12. She also had an order for milk of magnesia 30 milliliters by mouth two times as needed for constipation with an original start date of 6/3/12.</p> <p>Medication Administration Record (MAR) for July indicated Resident # 42 was administered milk of magnesia two times in the month of July on 7/21/13 which was ineffective and 7/28/13 which was ineffective.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the fluid restriction on 1 of 1 residents were properly recorded and failed to monitor 2 of 2 residents for bowel movements. (Resident #'s 74, 13 and 42).</p> <p>Findings include:</p> <p>1. The record for Resident #74 was reviewed on 7/31/13 at 2:00 p.m.</p> <p>Current diagnoses included, but were not limited to, End Stage Renal Disease, Diabetes, Hypertention, Stroke and Dementia. Resident #74 received dialysis on Tuesdays, Thursdays and Saturdays.</p> <p>Resident #74 was care planed for a fluid restriction of 2000 Milliliters of fluid a day with divided amounts given by Dietary and Nursing. Dietary provided 1440 milliliters of fluid and Nursing provided 555 Milliliters of fluid, divided into 180 milliliters given</p>	F000309	<p>Fluid intake for Resident #74 is now being recorded properly to include all fluids resident has consumed for the day. Bowel tracking forms reviewed for Resident #13 and Resident #42 with interventions given as appropriate. All residents with fluid restrictions have been reviewed. Fluid intakes for any resident identified to have been affected by the deficient practice are now being recorded properly to include all fluids resident has consumed for the day. Bowel tracking forms were reviewed for all residents for past 30 days. Any resident identified to have been affected by the deficient practice had an abdominal assessment completed with interventions given as appropriate per plan of care. Nursing staff in-serviced on recording fluid intakes for residents on fluid restrictions. CNA to document all fluid intakes for any resident on a fluid restriction on Fluid Intake Record form. This includes all fluids resident consumes during meals as well as any other fluids resident consumes during the</p>	09/01/2013	

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	<p>per shift, over three shifts. Meals were recorded by percentage of meal consumed and fluids were not recorded separately to be able to keep a record of the amount of the 1440 Milliliters given to Resident #74. The Nutritional Assessment of Resident #74 indicated the resident required a minimum of 2075 milliliters of fluid daily to maintain proper hydration.</p> <p>On 7/31/13 at 2:10 p.m., during an interview with LPN #7, she indicated Resident #74 was on a fluid restriction and the fluid was divided up between Dietary and Nursing and nursing's portion was divided up between shifts. When asked if they keep separate records of food and fluid consumption at meal time, LPN #7 indicated they do not separate the food consumption from the fluid consumption.</p> <p>2. Resident # 13's record was reviewed on 7/31/13 at 9:45 a.m. Her diagnoses included, but were not limited to, senile dementia</p>		<p>shift. The CNA turns this form in to the nurse at the end of the shift. The nurse will use this form to document the total amount of fluids the resident has consumed for the shift on the eMAR. Unit Manager/designee to review this form to ensure intake being accurately recorded. Nursing staff in-serviced on Bowel Management protocol which includes monitoring for bowel movements and recording them into Care Tracker system. Licensed nursing staff to review Care Tracker report for residents with no bowel movements for past 9 shifts and provide an intervention for any resident on this report per resident's plan of care. Unit Manager/designee to review this report to ensure appropriate interventions have been given for any resident on this list. These audits to be completed 5 times weekly x 30 days, 3 times weekly x 30 days, then 2 times weekly x 4 months. Results of these rounds to be reviewed at QAPI x 6 months to track for any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>				

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	<p>uncomplicated, unspecified constipation, pain in joint site, and pathologic fracture of neck of femur.</p> <p>Resident # 13's care plan dated 4/26/11 indicated she had a history of constipation and risk related to narcotic use with these interventions being used, and the goal for the resident was for her to have a bowel movement (BM) every third day with a target date of 10/29/13.</p> <ol style="list-style-type: none"> 1. Administer colace, dulcolax suppository and milk of magnesia as ordered 2. Encourage meal and fluid consumption 3. Encourage physical activity as tolerated 4. Observe BM pattern <p>Resident # 13's bowel movement (BM) record indicated she did not have a BM from 6/29/13 to 7/23/13 and 7/25/13 to 7/30/13. Resident had a BM on 7/24/13 and two BM's on 7/31/13.</p> <p>The physician's orders for July 2013 indicated the resident had an order for colace 100 milligrams two tablets daily. The original date of the order was 4/24/13 for a diagnosis of unspecified constipation. She also had an order for dulcolax suppository</p>			

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	<p>rectally as needed with an original date of 1/25/13 and milk of magnesia 30 milliliters by mouth as needed for constipation with an original order date of 1/25/13. The physician was notified of the resident's frequent constipation and new orders were given on 7/31/13 for a soap suds enema daily as needed and 8/1/13 for miralax daily.</p> <p>The Medication Administration Record (MAR) indicated Resident #13 had been administered MOM four times in the month of July on 7/22/13, 7/24/13, 7/28/13, and 7/29/13 all of which were documented as not effective. Dulcolax Suppository had been administered rectally two times once on 7/3/13 which was ineffective and on 7/31/13 was effective with two large BM's.</p> <p>During an interview on 7/31/13 at 3:10 p.m., the Alzheimer's Unit Manger indicated, Resident # 13 only had one BM this month on 7/24/13. She indicated a nurse went to do a bowel assessment on the resident this afternoon because she was not sure what is going on with this resident's abdomen.</p> <p>During an interview on 8/1/13 at 9:30 a.m., the Alzheimer's Unit Manager</p>				

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	<p>indicated, Resident # 13 had two large BM's last evening after she was administered a dulcolax suppository.</p> <p>During an interview on 8/1/13 at 2:05 p.m., CNA # 5 and CNA# 6 indicated when BM's are documented in the caretracker they have to answer yes or no as to whether they have or have not had a BM. They indicated they can not skip the question or leave it blank and if the answer to the question is answered as no then the resident did not have a BM.</p> <p>During an interview on 8/1/13 at 2:56 p.m., with Alzheimer's Unit Manager indicated the facility did not have an official bowel protocol to follow.</p> <p>The "Bowel Management Policy and Protocol" was received from the DON on 8/2/13 at 8:35 a.m. The DON indicated the facility had not been following this bowel protocol, but the nursing consultant had sent it to her as a policy to be used as their bowel protocol.</p> <p>3. Record review for Resident # 42 was completed on 7/31/13 at 2:30 p.m. Diagnoses included, but were not limited to legal blindness, Osteoarthritis, and senile dementia with depressive features.</p>						

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	<p>Resident # 42's care plan started on 3/18/13 indicated she had occasional problems with constipation with these interventions. The goal for this resident was to have a BM at least every three days with a target date of 9/6/13.</p> <ol style="list-style-type: none"> 1. Cue and encourage resident to consume all or her fluids and nutrition as tolerated 2. Give dulcolax, MOM 3. Monitor BM pattern <p>Resident # 42's bowel movement (BM) record indicated she did not have a BM from 7/21/13 to 7/28/13. Resident had a BM on 7/20/13 and 7/29/13.</p> <p>The physician's orders for July 2013 indicated the resident had an order for dulcolax suppository ten milligrams rectally daily as needed for constipation with an original start date of 8/23/12. She also had an order for milk of magnesia 30 milliliters by mouth two times as needed for constipation with an original start date of 6/3/12.</p> <p>Medication Administration Record (MAR) for July indicated Resident # 42 was administered milk of</p>						

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	magnesia two times in the month of July on 7/21/13 which was ineffective and 7/28/13 which was ineffective. 3.1-37(a)				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure residents in the main dining room were not exposed to fiber glass wool insulation during meal service. This deficit practice had the potential to effect 35 of 35 residents eating in the observed dining room. This occurred in 1 of 5 dining rooms.</p> <p>Findings include:</p> <p>During a meal observation, on 7/31/13 at 12:00 p.m., the Maintenance Director was observed working on the ice machine, in the main dining room, during meal service. Maintenance worker #2 walked though the main dining room carrying a 30 inch x 8 inch uncovered strip of fiber glass wool insulation needed to complete the repair of the ice machine.</p> <p>During an interview with the Maintenance Director, on 7/31/13 at 12:15 p.m., he indicated the fiber glass wool should not have been</p>	F000323	<p>Maintenance worker #2 was in-serviced about environmental safety in resident dining areas immediately and removed fiber glass wool insulation from dining room..</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Maintenance staff in-serviced on environmental safety in resident areas. Maintenance Director to observe dining room 5 times weekly x 30 days then 3 times weekly for 30 days, then weekly x 4 months. Any issues identified will be addressed at the time they are noted.</p> <p>Results of these rounds to be reviewed at QAPI x 6 months to track any trends.</p>	09/01/2013	

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	<p>carried through the dining room during meal service uncovered.</p> <p>A "Material Safety Data Sheet" received from the facility Administrator, on 8/2/13 at 3:30 p.m., indicated the following:</p> <p>"...Product Description: Fiber Glass Insulation</p> <p>...Emergency Overview</p> <p>This produce may cause temporary irritation to the upper respiratory system, eyes, and skin. Avoid inhalation, skin and eye contact as temporary irritation may occur. Wear appropriate personal protective equipment...."</p> <p>3.1-45(a)(1)</p>		<p>If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>		

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview the facility failed to prevent weight loss and follow Speech Therapy recommendations to prevent further weight loss for 1 of 5 residents reviewed for weight loss. (Resident #87) Findings include: The clinical record of Resident #87 was reviewed on 8/2/13 at 8:50 a.m. Diagnoses included, but were not limited to, dementia, hyperlipidemia, diabetes, heart disease, pain, and anxiety. Resident #87's weights were as follows: 1/24/2013: 121 pounds 4/18/2013: 121 pounds</p>	F000325	<p>Nursing staff in-serviced on Speech Therapy recommendations for Resident #87. All residents who are currently receiving ST or who have been discharged from ST in past 30 days were reviewed to ensure proper in-servicing was conducted if appropriate. In-servicing was completed for any resident who was found to be affected by the deficient practice. Therapy staff in-serviced on procedure and documentation for restorative program and therapy recommendations for discharge. Therapy staff to complete Rehab</p>	09/01/2013			

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	<p>6/06/2013: 124 pounds</p> <p>7/3/13: 109 pounds</p> <p>07/19/13: 111 pounds</p> <p>8/2/13: 112.2 pounds</p> <p>A Care Plan for involuntary weight loss dated 1/15/13 and reviewed 7/9/13, had interventions that included, but were not limited to, diet per order, monitor meal consumption and monitor weights as available. On 7/9/12, 2 Cal supplement and Registered Dietitian consult was added to the care plan.</p> <p>A Physicians order, dated 4/18/13, indicated ST (Speech Therapy) to evaluate and treat due to decreased intakes.</p> <p>A Speech "Therapist Progress & Discharge Summary," dated 4/18/13 through 7/8/13, indicated "...Patient/Caregiver Training: completed. Summary of Skilled Services Provided...: skilled evaluation, development of POC (plan of care), skilled cueing, skilled hierarchy of pal tasks, skilled training with staff...."</p>		<p>Follow Up/Restorative form for any resident requiring recommendations.</p> <p>Therapy staff to document on this form any facility staff that were trained on these recommendations. A copy of this form will be given to Director of Rehab and will be taken to morning meeting every business day with copies provided to each UM/designee. A copy will also be placed in a binder on each unit for future reference for staff.</p> <p>Director of Rehab to review these forms every business day to ensure proper in-servicing was conducted.</p> <p>Results of these audits to be reviewed at QAPI monthly to track for any trends. If any trend identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>				

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	<p>A Speech Therapy Functional Maintenance Program, dated 7/8/13, indicated, give extra time for communication, encourage stimulation and talking at meals, alternate liquids and solids at meal, and encourage hydration between meals. These instructions/recommendations were not added to the care plan.</p> <p>A Registered Dietitian note dated 7/12/13, did not indicate any recommendations at that time due to the antidepressant having been restarted.</p> <p>During an interview with CNA #10, on 8/2/13 at 10:50 a.m., she indicated she was not aware of any special instructions regarding Resident #87 or the ST recommendations. CNA #10 also indicated Resident #87 feeds herself.</p> <p>3.1-46(a)(1)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview, and record review, the facility failed to ensure that antidepressant medications (medications used to manage depression) were reviewed for Gradual Dose Reduction annually for 1 of 10 residents (Resident #29) and failed to ensure resident medications requiring specific monitoring was monitored for 1 of 10 residents (Resident #131) reviewed for unnecessary medications.</p>	F000329	<p>Resident #29 was seen by Dr. Spangler on 8-6-13 with a new order to decrease her remeron. eMAR for Resident #131 has been updated to include recording the pulse when giving lanoxin.</p> <p>All residents on antidepressants have been reviewed to ensure a GDR has been attempted per</p>	09/01/2013	

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	<p>Findings include:</p> <p>1. Resident #29's record was reviewed on 7/30/13 at 1:55 p.m. Current diagnoses included, but were not limited to, diabetes, anxiety state, heart disease without heart failure, hypertension, acute myocardial infarct, mood disorder, insomnia, Alzheimer's Disease, senile dementia with depressive features and depressive disorder.</p> <p>The resident was currently receiving the following medications, on a daily basis, Remeron (Antidepressant) originally ordered on 1/4/2011 and Wellbutrin Slow Release (Antidepressant) originally ordered on 6/7/2010.</p> <p>The record indicated a GDR (Gradual Dose Reduction) had a last Consultant Pharmacist Communication to the Physician review period dated 03/2012 for Remeron 30 milligrams and Wellbutrin SR 150 milligrams, both being used as a antidepressant.</p> <p>The physician indicated on 4/3/12, "An attempted GDR is likely to result in impairment of function or increased distressed behavior. "Chronic depression - very high risk of</p>		<p>facility guidelines. MD was notified with recommendations as appropriate for GDR for any resident found to have been affected by the deficient practice. All residents' medication orders reviewed to ensure any medications requiring specific monitoring is being monitored. Residents' eMARs have been updated to include appropriate monitoring (BP, pulse, etc) for medications requiring specific monitoring for any resident found to have been affected by the deficient practice.</p> <p>Any resident on a psychoactive medication will have a tracking form completed to monitor all psychoactive medications and attempts made for GDR. UM/designee to review new orders 5 times weekly for any new orders/changes made regarding psychoactive medications. These new orders/changes will be updated on tracking form.</p>		

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	<p>recurrent [SIC] if [decrease] done."</p> <p>During an interview on 8/1/13 at 1:09 p.m., with the Alzheimer's Unit Manager, indicated she was "unable to find another GDR, only one she was able to find was dated 4/3/12."</p> <p>Review of current facility policy titled "Medication Monitoring/Medication Monitoring, " which was provided by the Director of Nursing on 8/2/13 at 2:15 p.m., indicated the following:</p> <p>"In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, the facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and non-pharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition...</p> <p>Other Psychopharmacological Medications. During the first year in which a resident is admitted on a psychopharmacological medication</p>		<p>Tracking forms will be reviewed at monthly behavior meeting to ensure GDR being attempted per facility guidelines for all psychoactive medications. Licensed nursing staff in-serviced on ensuring that monitoring is being completed for medications that require specific monitoring. UM/designee to review new orders 5 times weekly to check and make sure that any medication requiring specific monitoring has had information inputted into the order so that the specific monitoring is being documented on the eMAR. Any issues identified will be addressed at the time they are noted.</p> <p>The results of these audits to be reviewed at QAPI monthly x 6 months to track for any trends. If any trends identified then audits to be completed based on QAPI recommendation. If no trends identified then will review on a PRN basis.</p>	

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	<p>(other than a antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility attempts a GDR during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated...."</p> <p>2. Resident # 131's record was reviewed on 8/1/13 at 9:40 a.m. Diagnoses included, but were not limited to, atrial fibrillation, chronic venous hypertension and acute renal failure.</p> <p>Resident #131 had an order for digoxin 0.125 milligrams by mouth one half tab daily started on 7/16/13 and a new order was written on 7/24/13 to include the order to hold if the apical pulse was less than 60.</p> <p>The Medication Administration Record (MAR) for July did not indicate any pulses in the box designated for apical pulses for the dates of 7/25/13, 7/26/13, 7/27/13/, 7/28/13, 7/29/13, 7/30/13 or 7/31/13.</p> <p>During an interview on 8/1/13 at 9:45 a.m., with the Alzheimer Unit Manager she indicated if the nurses would have documented the pulse in</p>			

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	<p>the box designated for the apical pulse on the MAR it would have printed out on the MAR. She indicated she could not find any other pulses documented in the record except for 7/29/13.</p> <p>3.1-48(a)(3) 3.1-48(b)(2)</p>				

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F000364 SS=E	<p>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 observation and interview, the facility failed to ensure palatability of meals for 4 of 7 residents out of a sample of 7 residents (Resident # 6, # 37, # 17 and # 121)</p> <p>Findings include:</p> <ol style="list-style-type: none"> During the interview with Resident # 6 on 7/30/13 at 10:12 a.m., she indicated the cooked vegetables were as hard as a "rock" and she could not chew peas and carrots because they tasted like they were frozen. She indicated she had eaten very little and had gone to bed hungry a lot of times at night when she did not eat peanut butter and jelly sandwiches. She indicated she had to "hound" the staff to receive the peanut butter and jelly sandwiches and that the food was "so bad" that she could not eat it because she could not eat food that was not appetizing. She indicated the hot food was cold. During an interview with Resident #17 on 7/30/13 at 9:34 a.m., Resident #17 indicated that she thought the 	F000364	The dietary staff were in-serviced on food temperatures and cooking procedures and snack delivery. The nursing staff were in serviced on between meal snack delivery. At least 3 residents will be interviewed for temperature palatability daily five times per week for 4 weeks. Monitoring will then be 3 times per week for an additional 8 weeks. Food serving temperatures will be monitored daily five times per week for 4 weeks. Monitoring will then be 3 x week for 8 weeks then weekly for 3 months. The Dietary Manager and/or the Registered Dietitian will meet with the residents in food committee weekly for 4 weeks and then monthly for an additional 2 months. Dietary Manager to report results to QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.	09/01/2013			

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	<p>food was bad and did not taste right. She had her daughter bring in lunch for her on a daily basis and only ate part of the meals that the facility prepared her.</p> <p>During an interview with Resident #17 on 7/31/13 2:10 p.m., Resident #17 indicated she only ate the fish and the jello because the rest of the meal didn't taste very good.</p> <p>3. During an interview with Resident #37 on 7/29/2013 at 3:17 p.m., Resident #37 indicated the food served in the facility was too spicy and they served too many tomato products for her taste.</p> <p>4. During an interview with Resident #121 on 7/31/13 at 12:12 p.m., the resident stated "the food is awful, meat too tough, hard for me to chew, just too tough I can't cut it up...sometimes they cut it up for me when I ask..."</p> <p>Food is too spicy, too much food on my plate and they expect you to eat it all...."</p> <p>A test tray was requested and received on 8/1/13 at 12:25 p.m., the facility Dietician and Dietary Manager were present. The test tray included:</p>			

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	<p>roast beef, cauliflower, sweet potato salad and banana split pudding.</p> <p>The test tray indicated the following:</p> <p>The roast beef was spicy to taste with seasoning of multiple variations of spices and a temperature of 123.6 degrees Fahrenheit, below the serving temperature.</p> <p>The cauliflower had a temperature of 149.1 degrees Fahrenheit.</p> <p>The sweet potato salad had a temperature of 55.1 degrees Fahrenheit.</p> <p>The banana split pudding had a temperature of 49.8 degrees Fahrenheit.</p> <p>3.1-21(a)(2)</p>			

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions. This deficit practice had the potential to affect 100 of 101 residents served food from the kitchen.</p> <p>Findings include:</p> <p>1. A tour of the kitchen was conducted on 7/29/13 at 9:13 a.m., with the Dietary Service Manager and the Consultant Dietician.</p> <p>Three dented canned food items were observed on the dry storage shelves in the kitchen. The dented cans were observed being placed in the dietary office on 7/29/13 at 9:45 a.m.</p> <p>During an interview with the Dietary Service Manager on 7/29/13 at 9:50 a.m., regarding the dented canned food, he stated "The policy is to remove the cans from storage and send back the dented cans."</p>	F000371	<p>The Dining Services Manager removed all dented cans from food storage area into a labeled 'dented can- do not use' section on 7/29/13. The two food preparation shelves were cleaned and utensils were re-sanitized on 8/1/13. The bottom shelf of the steam table was cleaned on 8/1/13. The four stained divided plates were discarded on 8/1/13. The pureed food contaminated by cook #11 was discarded and not served to any residents on 8/1/13. Cook #11 was educated on hand hygiene on 8/1/13</p> <p>The dietary staff were educated on cleaning schedules and procedures on 8/20/13.</p> <p>Sanitation will be monitored</p>	09/01/2013			

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	<p>2. A tour of the kitchen was conducted on 8/1/13 at 10:45 a.m., with the Dietary Service Manager.</p> <p>Food debris was observed on two separate shelves with clean utensils stored ready for use. The two shelves were located in the food preparation area, one shelf by the steamer and the second shelf was located by the convention oven.</p> <p>A dried white substance was observed on the bottom shelf of the steam table.</p> <p>Four of four divided plates of pastel color were observed with a brown stain.</p> <p>During an interview with the Dietary Service Manager on 8/1/13 at 11:00 a.m., regarding the cleaning schedule of the kitchen and quality assurance (QA), he stated "the standard is weekly cleaning and I complete the QA."</p> <p>3. During an observation of pureed food preparation in the kitchen on 8/1/11 at 11:25 a.m., Cook #11 after preparing the puree of broccoli and cauliflower, Cook #11 checked the texture of the puree by placing her</p>		<p>by the Dietary manager daily five times per week for 4 weeks. Monitoring will then be 3 times per week for an additional 8 weeks then weekly x 3 months</p> <p>Dietary Manager to report results to QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>		

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	<p>ungloved finger into her mouth., then stated "it's good see." Cook #11 then picked up the container with her ungloved hands, took the container to a table next to the dietary office. Cook #11 then placed saran wrap over the container, checked the temperature of the puree with a thermometer and then placed the container into the steam table without washing her hands.</p> <p>During an interview with the Dietary Service Manager and Consultant Dietician on 8/2/13 at 12:30 p.m., the Consultant Dietician stated, "All of the contaminated puree food of broccoli and cauliflower was thrown out."</p> <p>3.1-21(i)(3)</p>				

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F000406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview the facility failed to have a yearly review of a residents PASARR II (PreAdmission Screening And Resident Review Level II) for 1 of 1 residents reviewed for residents requiring a PreAdmission Screening And Resident Review Level II (Resident #45).</p> <p>Findings include:</p> <p>Resident #45's clinical record was reviewed on 8/1/13 at 1:10 p.m.</p> <p>Resident #45's current diagnoses included, but were not limited to, Cerebral Palsy and Depression.</p> <p>The most current PASARR II in resident #45's chart, dated 2/9/11, indicate the resident was mentally ill</p>	F000406	<p>Social Services Specialist contacted local mental health agency (Howard Community Health) and scheduled PASSAR II assessment for resident #45 on August 29, 2013.</p> <p>Social Services Specialist performed 100% audit of all residents to identify other residents that may need yearly reviews of PASSAR II.</p> <p>Social Services Specialist will keep a list of residents that require PASSAR II and when annual reviews are due (if appropriate). This list will be updated monthly with any resident changes</p>	09/01/2013	

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	<p>and did not require specialized services with a recommendation for a yearly review.</p> <p>During a staff interview on 8/1/13 at 2:05 p.m., with the Social Service Specialist indicated he was unaware he was to follow up with residents PASARR II. He indicated he had placed a call to their area representative for the Agency of the Aged.</p> <p>During a staff interview on 8/1/13 at 2:30 p.m., the Business Office Manager indicated their area representative for the Agency of the Aged had stated it was the responsibility of the person who completed the PASARR II to put it on a tickler file and monitor if it was done yearly. She indicated that they did not have a written facility policy regarding the PASARR II.</p> <p>3.1-23(a) (2)</p>		<p>(admissions and/or discharges).</p> <p>Social Services Specialist will submit updated list of PASSAR II residents with annual reviews to the QAPI Committee on a monthly basis for the next six months.</p>		

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview, and record review, the facility failed to ensure the pharmacy reviewed the medication regimen and reported gradual dose reductions for 1 of 10 residents reviewed for unnecessary medications (Resident # 29).</p> <p>Findings include:</p> <p>1. Resident #29's record was reviewed on 7/30/13 at 1:55 p.m. Current diagnoses included, but were not limited to, diabetes, anxiety state, heart disease without heart failure, hypertension, acute myocardial infarct, mood disorder, insomnia, Alzheimer's Disease, senile dementia with depressive features and depressive disorder.</p> <p>The resident was currently receiving the following medication, on a daily basis, Remeron (Antidepressant) originally ordered on 1/4/2011 and Wellbutrin Slow Release</p>	F000428	Resident #29 was seen by Dr. Spangler on 8-6-13 with a new order to decrease her remeron. Pharmacist has reviewed medication regimen of all residents and made recommendations regarding GDR as appropriate for any resident found to have been affected by the deficient practice. Any resident on a psychoactive medication will have a tracking form completed to monitor all psychoactive medications and attempts made for GDR. Monitoring when the consultant pharmacist last reviewed medications will also be on this tracking form. Tracking forms will be reviewed at monthly behavior meeting by UM/designee to ensure GDR being attempted per facility guidelines for all psychoactive medications and that consultant pharmacist has reviewed medication regimen also. The results of these audits to be reviewed at QAPI monthly x 6 months to track for any trends. If any trends identified then audits to be completed based on QAPI	09/01/2013	

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	<p>(Antidepressant) originally ordered on 6/7/2010.</p> <p>A document titled "Clinical Pharmacist Medication Regimen Review Summary, dated 1/31/13 through 7/23/13," indicated that no pharmacy recommendation had been completed for Remeron or Wellbutrin.</p> <p>The clinical record indicated a GDR (Gradual Dose Reduction) had a last Consultant Pharmacist Communication to the Physician review period dated 03/2012 for Remeron 30 milligrams and Wellbutrin SR 150 milligrams, both being used as a antidepressant.</p> <p>During an interview on 8/1/13 at 3:34 p.m., with the Alzheimer's Unit Manager, she indicated no further documents regarding a pharmacy review for Remeron. No other information was provided as of exit on 8/2/13 at 4:00 p.m.</p> <p>Review of current facility policy titled "Medication Monitoring/Medication Monitoring, " which was provided by the Director of Nursing on 8/2/13 at 2:15 p.m., indicated the following:</p> <p>"In order to optimize the therapeutic benefit of medication therapy and</p>		<p>recommendation. If no trends identified then will review on a PRN basis.</p>		

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	<p>minimize or prevent potential adverse consequences, the facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and non-pharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition...</p> <p>Other Psychopharmacological Medications. During the first year in which a resident is admitted on a psychopharmacological medication (other than a antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility attempts a GDR during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated...."</p> <p>3.1-25(h)</p>				

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to develop and implement appropriate plans of action to address residents concerns and update to resident's concerns, did not identify residents who have been without a bowel movement for three days for 2 out of 2 residents, fluid restrictions with dialysis resident and no intake and output for 1 out of 1 resident, main dining room tables to tall for residents to eat for 3 out of 3</p>	F000520	<p>Adhoc QAPI meeting held to address the alleged deficient practices of the facility identified on the 2567. The facility is submitting this Plan of Correction to address the deficiencies identified on the 2567. All residents have the potential to be affected by the deficient practice.</p> <p>The facility leadership was in-serviced on the purpose of the QAPI process used at the facility and informing the QAPI committee of identification of concerns and modification and correction of</p>	09/01/2013			

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	<p>residents, lack of gradual dose reduction for 1 of 10 residents, stained, cracked and marred floored, dietary sanitation, liability notices were not provided the appropriate time frame, and Level two's were not done in the appropriate time frame. (Residents # 13, #17, #29, #37, #40, #42, #45, #59, #74, #127)</p> <p>Findings include:</p> <p>During an interview with the Administrator on 8/2/13 at 1:08 p.m., the Administrator was queried regarding Quality Assurance and Assessment (QAA) and the identified concerns of the annual survey as follows:</p> <ol style="list-style-type: none"> 1. Addressing resident's concerns and update to resident's concerns regarding resident council meeting minutes. 2. Not identifying bowel movements as a problem after three days without the residents having a bowel movement (Resident # 13 & # 42) 3. Fluid restrictions with dialysis resident and no intake and output. (Resident #74) 4. Tables in the main dining room to high for residents to self feed. (Residents #17, # 37, and # 127) 5. Lack of gradual dose reduction. (Resident # 29) 		<p>facility systems when needed. The Executive Director will ensure the QAPI team is developing plans of action to correct deficiencies and that the team is monitoring the effects of the corrections.</p>				

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	<p>6. Dietary sanitation</p> <p>7. Liability notices not completed in an appropriate time frame (Resident #40 and # 59)</p> <p>8. Level II assessments not completed in an appropriate time frame (Resident #45)</p> <p>The Administrator indicated none of the concerns except resident's concerns and the main dining room floor had been included in the facility QAA program.</p> <p>3.1-52(b)(2)</p>				