

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2015
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 16, 17, 18, 19, 20, and 23, 2015</p> <p>Facility number: 000515 Provider number: 155608 AIM number: 100290820</p> <p>Survey team: Caitlyn Doyle, RN-TC Jennifer Redlin, RN Heather Hite, RN Julie Ferguson, RN (February 19, 20, and 23, 2015) Regina Sanders, RN (February 16)</p> <p>Census bed type: SNF: 24 SNF/NF: 113 Total: 137</p> <p>Census payor type: Medicare: 34 Medicaid: 65 Other: 38 Total: 137</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 000	<p>Please accept this plan of correction as our allegation of compliance. This plan of correction is being submitted for the purpose of complying with regulatory requirements and in no way should be deemed as an admission of any of allegations contained within the survey findings.</p> <p>I would kindly request paper compliance on survey event ID QDYQ11 of Annual Survey dated February 23, 2015</p> <p>Respectfully submitted John J Hurley, MBA, LNHA Executive Director</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 221 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed on February 28, 2015, by Janelyn Kulik, RN.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was free from a physical restraint without the proper indications for use for 1 of 1 residents reviewed for physical restraints. (Resident #65)</p> <p>Finding includes:</p> <p>Observation on 2/17/15 at 9:05 a.m., Resident #65 was sitting in a Broda Chair with a lap tray attached to the chair and buckled around the back of the chair. The Broda Chair was slightly reclined with the resident's legs elevated. The resident's eyes were closed and she was sitting in an upright position and not leaning. There were no items on top of the lap tray.</p> <p>Observation on 2/18/15 at 10:23 a.m.,</p>	F 221	<p>F221 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #65 was re-assessed and restraint reduction was implemented on 3/11/15 <p>How are resident shaving the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> All residents with Devices that could be considered a restraint and known restraints were re-assessed and no deficiencies were identified. <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur</p> <ul style="list-style-type: none"> All residents with devices that could be considered restraints and known restraints will be 	03/25/2015

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	<p>Resident #65 was sitting in a Broda Chair with a lap tray attached to the chair and buckled around the back of the chair. The Broda Chair was slightly reclined with the resident's legs elevated on a leg rest. The resident was sitting upright and not leaning, her eyes were closed and her arms crossed on top of the tray. There were no items on top of the lap tray.</p> <p>Observation on 2/18/15 at 1:16 p.m., Resident #65 was sitting in a Broda Chair in her room with a lap tray attached to the chair and buckled around the back of the chair. The Broda Chair was slightly reclined with the resident's legs elevated. The resident was sitting on a waffle cushion in the chair. The resident's eyes were closed, she was sitting in an upright position in the chair with her arms crossed over the lap tray. The resident was not leaning in the chair. There were no items on top of the lap tray.</p> <p>Observation on 2/19/15 at 11:18 a.m., Resident #65 was sitting in a Broda Chair in her room with a lap tray attached to the chair and buckled around the back of the chair. The Broda Chair was slightly reclined with the resident's legs downward on a foot rest. The resident was sitting upright and not leaning, her eyes were closed, and her arms were crossed across her body. There were no</p>		<p>reviewed monthly by IDT clinical at risk meeting to verify assessments are completed, reductions are attempted and least restrictive device is in place. All staff will be re-in-serviced on restraint use and reduction requirements.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p> <ul style="list-style-type: none"> -DHCS or designee will monitor 5 restraint assessments for accuracy and completion each week, including reduction attempts. Findings will be reported in QualityAssurance meeting monthly for 90 days or until 100% compliance is reached. <p>By what date the systemic changes will be completed</p> <ul style="list-style-type: none"> -All systematic changes will be completed by March25, 2015 		

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	<p>items on top of the lap tray.</p> <p>Observation on 2/19/15 at 2:17 p.m., Resident #65 was sitting in a Broda Chair in her room with a lap tray attached to the chair and buckled around the back of the chair. The back of the Broda Chair was straight up with the resident's feet downward on a foot rest. The resident was sitting upright in the chair and not leaning, her eyes were closed and her arms were crossed over her body. There were no items on top of the lap tray.</p> <p>Observation on 2/20/15 at 10:02 a.m., Resident #65 was sitting in a recliner in her room with a lap tray attached to the chair and buckled around the back of the chair. The recliner was slightly reclined with her legs elevated. The resident was sitting in an upright position and not leaning, her eyes were closed and her arms were crossed over her chest. There were no items on top of the lap tray</p> <p>Record review for Resident #65 was completed on 2/18/15 at 10:38 a.m. The residents diagnoses included, but were not limited to, diabetes mellitus, unsteady gait, cognitive impairment, and dementia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 12/10/14 indicated the resident was severely</p>				

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	<p>cognitively impaired. The Activities of Daily Living (ADLs) indicated the resident was an extensive 2+ person assist for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident was an extensive 1 person assist for locomotion and eating. The resident had no physical limitation in range of motion for bilateral upper and lower extremities. The resident had no falls since admission. The assessment indicated the resident had a restraint of a chair that prevents rising and was used daily.</p> <p>Review of the February 2015 Physician Order Summary indicated a Broda Chair with Lap tray to be used when up due to poor trunk control and decreased safety awareness due to dementia and closed head injury.</p> <p>A care plan for ADL Function Rehab dated 6/18/14 indicated: Impaired physical mobility due to history of traumatic brain injury that resulted in severely impaired cognition as evidenced by needing extensive to total assist with all ADLs. Unable to make her needs known to staff and staff anticipates all of her needs throughout the day. Requires use of a restraint (lap tray to Broda Chair and while she is in recliner) due to poor trunk control and decreased safety</p>			

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	<p>awareness due to dementia and closed head injury. Interventions dated 6/18/14 included Broda Chair with lap tray as ordered. Check and release restraint throughout the day.</p> <p>Review of the January and February 2015 Restraint Record indicated the resident's restraint was checked hourly and released temporarily every 2 hours.</p> <p>Review of the Treatment Record for February 2015 indicated the lap tray was attached to the Broda Chair everyday.</p> <p>Review of the residents record indicated no assessment of the restraint had been completed since 9/10/13. The restraint assessment at the time indicated: Broda Chair lap tray due to poor trunk control and safety. Under comment section indicated therapy to review to decrease if possible. Efforts to reduce the use of the restraint: Therapy to screen for positioning/trunk control to try to reduce restraint.</p> <p>Review of the Occupational Therapy (OT) Plan of Care dated 12/22/14 indicated Resident #65 was referred to skilled OT for wheelchair positioning. The Therapy Notes indicated the resident was observed in a Broda Chair with right lateral leaning and a full lap tray and</p>			

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	<p>bilateral leg rest was applied to the chair. The goal was for the resident to demonstrate adequate and functional positioning while seated in the Broda Chair x 1-2 hours with no evidence of right lateral leaning.</p> <p>Review of the Occupational Therapy Progress and Discharge Summary dated 1/2/15 indicated the resident had met her goal. The summary indicated nursing staff was educated on proper placement of resident in wheelchair with hip in neutral alignment to reduce the risk of right lateral leaning. The Therapy Notes indicated therapy attempted to discontinue the lap tray, however, family was resistant to the change. Therapy discussed and educated the family on positioning without the lap tray, they did not want it removed at the time.</p> <p>A Social Service Progress note dated 1/15/14 indicated: Care plan conference held today with resident's son and Interdisciplinary Team, resident did not attend due to cognition. Discussed use of tray, son does not want no tray and no alarm, he would be fine with one or another. The note indicated the resident does enjoy the tray as she will have items on it in front of her at times and it was no longer considered a restraint due to the resident does not have the ability to stand</p>			

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	<p>per self so tray does not restrict her.</p> <p>Interview with Occupational Therapist #1 on 2/18/15 at 11:55 a.m., indicated the resident was referred to therapy for leaning in her Broda Chair. The resident met her goal and was discharged from therapy. She further indicated there was no medical necessity for the lap tray and indicated she was aware it was considered a restraint and recommended the lap tray be discontinued. The therapist indicated the Broda Chair was all the resident needed for positioning. She further indicated this was expressed to nursing and they indicated the family does not want the lap tray removed.</p> <p>Interview with RN #1 on 2/18/15 at 1:21 p.m., indicated the resident had a lap tray for positioning. She indicated nursing was supposed to do quarterly assessments on restraints. She further indicated the lap tray was there per family request.</p> <p>Interview with the Administrator and the Assistant Director of Nursing (ADoN) on 2/18/15 at 1:52 p.m., indicated no quarterly assessments have been done for the restraint because they were not considering the lap tray a restraint.</p> <p>Interview with the Director of Rehab on 2/20/15 at 10:22 a.m., indicated the</p>			

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	<p>resident had not been seen by therapy for a screen for a reduction of the restraint. She further indicated the resident was being seen in Occupational Therapy from December 2014 - January 2015 for leaning in her Broda Chair. At the discharge of therapy it was attempted to discontinue the lap tray and according to nursing the family did not want this.</p> <p>A Restraint/Assistive Device Assessment completed on 2/18/15 indicated restraint recommendation was for a lap tray. The assessment of physical ability indicated: sitting balance = fair, standing balance = poor, ability to maintain proper sitting position = fair, physical endurance/strength = fair, visual acuity = fair, judgment/safety = poor, cognitive status = poor. The indication for use: Resident at times uses lap tray for activities, and has poor trunk control.</p> <p>A facility policy, titled Restraints Physical and Restraint Reduction, and received as current form the Administrator and ADoN on 2/18/15 at 1:52 p.m., indicated ..."5. If physical restraints must be used, they are to be considered short term: Assessment will be done by the interdisciplinary team. 6. Physical Restraints shall be defined as any device, material or equipment attached or adjacent to the resident's body</p>			

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F 241 SS=E Bldg. 00	<p>that the individual cannot remove easily, thus restricting freedom of movement or normal access to one's body. 7. Order for restraint to be reviewed quarterly. Each resident who is restrained must be reassessed every three months or less as indicated and as appropriate reduction programs are begun..."</p> <p>3.1-3(w) 3.1-26(a) 3.1-26(o)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to promote dignity during dining service related to not serving all residents at the same table together, resulting in at least one resident at any given table watching others eat a meal while waiting to be served. (Large Main Dining Area)</p> <p>Finding includes:</p>	F 241	<p>F241 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents eating in the main dining room were affected by the deficient practice. A new service policy regarding timely meal service was effective 2/24/15.</p> <p>How are residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	03/25/2015

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	<p>During a lunch service observation in the large area of the Main Dining room on 02/17/2015 at 11:27 a.m., 35 residents were seated at 10 different tables. Dining staff was observed randomly delivering individual plates from the steam table to residents at all different tables. At least one or two residents at all of the 10 tables were waiting at least 10 minutes for food while other residents at their table were already eating.</p> <p>At 11:38 a.m., Resident #5 was still waiting for her food while two other residents ate their lunch. She indicated the food "was always served like that. When they get to your name in the stack of papers, they bring your food. I don't like waiting, but we just have to be patient, I guess."</p> <p>At 11:48 a.m., Resident #22 was still waiting to be served her food while the other three residents at the table had been eating for at least 15 minutes. Resident #22 indicated she "would like to eat with the rest of the people at my table, but that's just the way they do it."</p> <p>At 11:58 a.m., the last meal was served. By the time the last resident at every table was served, at least one of the other residents at the table had finished eating.</p>		<p>action will be taken.</p> <ul style="list-style-type: none"> All residents were affected and experienced the new meal service change on 2/24/15. With the creation of the new service policy the potential for this deficient practice has been eliminated. <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur.</p> <ul style="list-style-type: none"> An in-service was conducted on 2/26/15 with all Directors and Culinary staff on the deficient practice regarding the new policy and expectation. Audit created to ensure timely resident meal service. <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p> <ul style="list-style-type: none"> Meal managers are in place for all meals and have been made aware of new policy and expectation. Additionally, an audit form has been created to monitor for compliance. Audit to be conducted 5 days per week for 90 days or until 100% compliant. Findings will be reported in QA monthly meetings for 90 days or until 100% compliance is reached. <p>By what date the systemic changes will be completed</p> <ul style="list-style-type: none"> All systematic changes will be completed by March 25, 2015 	

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	<p>During a lunch service observation in the large area of the Main Dining room on 02/20/2015 at 11:45 a.m., residents were seated at 10 different tables and lunch service had already begun. At one table, one resident was eating while two waited for food, the last resident at this table was still without food at 11:56 a.m. At another table, one resident was eating and two residents were waiting for food. At a third table, one resident was finished eating at 11:50 a.m. and the other two residents were still waiting to be served, with one of the two still without food at 11:56 a.m.</p> <p>Interview with Dietary Aide #1 on 02/20/2015 at 11:53, indicated the routine protocol for serving meals was to have the residents' meal tickets set out on their tables. When each resident arrived to the table, staff offered drinks, then turned the meal ticket in to the steam table to have that meal plated and served.</p> <p>Interview with the Culinary Services Director on 02/23/2015 at 9:21 AM, indicated he had changed the process to have residents come sit at dining tables earlier and be served drinks to avoid a line outside the dining area and the potential for resident conflicts. Further indicated he probably needed to revisit how the dietary aides handle meal tickets</p>			

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	<p>and understood the issue with residents at the same table receiving food at such varied times during a meal service.</p> <p>Follow up interview with the Culinary services director on 02/23/2015 at 1:28 PM, indicated the facility had changed methods about a year ago to having residents come into the dining room and sit at tables earlier to avoid waiting in the hallway, but had mainly started with just serving drinks and having entertainment. Then, after a couple months, the food council indicated some residents were upset with having to wait while seated in the dining room without having food, so he started the current method of having dining tickets and serving as they came in. He further indicated, "to address the issue of residents at the same table having to watch others eat while still waiting for food, for lunch today, the dining staff came up with the idea of gathering the tickets as the residents came in the dining room and separating them by table at the steam table, then serving by table when at least 2 or 3 residents from a table were present." He indicated at this time there were no minutes from the food council meetings to indicate any resident request or response to serving meals in the order in which residents entered the dining area and not by tables. The new method will</p>			

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F 272 SS=D Bldg. 00	<p>be discussed at the next food council meeting.</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; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in</p>			

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	<p>assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure quarterly assessments were completed for a resident with a physical restraint for 1 of 1 residents reviewed for physical restraints. (Resident #65)</p> <p>Finding includes:</p> <p>Observation on 2/17/15 at 9:05 a.m., Resident #65 was sitting in a Broda Chair with a lap tray attached to the chair and buckled around the back of the chair. The Broda Chair was slightly reclined with the resident's legs elevated. The resident's eyes were closed and she was sitting in an upright position and not leaning. There were no items on top of the lap tray.</p> <p>Observation on 2/20/15 at 10:02 a.m., Resident #65 was sitting in a recliner in her room with a lap tray attached to the chair and buckled around the back of the chair. The recliner was slightly reclined with her legs elevated. The resident was sitting in an upright position and not leaning, her eyes were closed and her arms were crossed over her chest. There were no items on top of the lap tray</p> <p>Record review for Resident #65 was completed on 2/18/15 at 10:38 a.m. The</p>	F 272	<p>F272 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #65 was re-assessed and restraint reduction was implemented on 3/11/15 <p>How are resident shaving the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> All residents with Devices that could be considered a restraint and known restraints were re-assessed and no deficiencies were identified. <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur</p> <ul style="list-style-type: none"> All residents with devices that could be considered restraints and known restraints will be reviewed monthly by IDT clinical at risk meeting to verify assessment completed, reductions attempted and least restrictive device is in place. All staff will be in-service on restraint use and reduction requirements <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p> <ul style="list-style-type: none"> DHCS or designee will monitor 5 restraint assessments for 	03/25/2015

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	<p>residents diagnoses included, but were not limited to, diabetes mellitus, unsteady gait, cognitive impairment, and dementia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 12/10/14 indicated the resident was severely cognitively impaired. The Activities of Daily Living (ADLs) indicated the resident was an extensive 2+ person assist for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident was an extensive 1 person assist for locomotion and eating. The resident had no physical limitation in range of motion for bilateral upper and lower extremities. The resident had no falls since admission. The assessment indicated the resident had a restraint of a chair that prevents rising and was used daily.</p> <p>Review of the February 2015 Physician Order Summary indicated a Broda Chair with Lap tray to be used when up due to poor trunk control and decreased safety awareness due to dementia and closed head injury.</p> <p>A care plan for ADL Function Rehab dated 6/18/14 indicated: Impaired physical mobility due to history of traumatic brain injury that resulted in severely impaired cognition as evidenced</p>		<p>accuracy and completion each week, including reduction attempts. Findings will be reported in Quality Assurance meeting monthly for 90 days or until 100% compliance is reached.</p> <p>By what date the systemic changes will be completed</p> <p>All systematic changes will be completed by March 25, 2015</p>	

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	<p>by needing extensive to total assist with all ADLs. Unable to make her needs known to staff and staff anticipates all of her needs throughout the day. Requires use of a restraint (lap tray to Broda Chair and while she is in recliner) due to poor trunk control and decreased safety awareness due to dementia and closed head injury. Interventions dated 6/18/14 included Broda Chair with lap tray as ordered. Check and release restraint throughout the day.</p> <p>Review of the Treatment Record for February 2015 indicated the lap tray was attached to the Broda Chair everyday.</p> <p>Review of the residents record indicated no assessment of the restraint had been completed since 9/10/13. The restraint assessment at the time indicated: Broda Chair lap tray due to poor trunk control and safety. Under comment section indicated therapy to review to decrease if possible. Efforts to reduce the use of the restraint: Therapy to screen for positioning/trunk control to try to reduce restraint.</p> <p>Interview with RN #1 on 2/18/15 at 1:21 p.m., indicated the resident had a lap tray for positioning. She indicated nursing was supposed to do quarterly assessments on restraints. She further indicated the</p>			

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	<p>lap tray is there per family request.</p> <p>Interview with the Administrator and the Assistant Director of Nursing (ADoN) on 2/18/15 at 1:52 p.m., indicated no quarterly assessments have been done for the restraint because they were not considering the lap tray a restraint.</p> <p>A Restraint/Assistive Device Assessment completed on 2/18/15 indicated restraint recommendation was for a lap tray. The assessment of physical ability indicated: sitting balance = fair, standing balance = poor, ability to maintain proper sitting position = fair, physical endurance/strength = fair, visual acuity = fair, judgment/safety = poor, cognitive status = poor. The indication for use: Resident at times uses lap tray for activities, and has poor trunk control.</p> <p>A facility policy, titled Restraints Physical and Restraint Reduction, and received as current form the Administrator and ADoN on 2/18/15 at 1:52 p.m., indicated ..."5. If physical restraints must be used, they are to be considered short term: Assessment will be done by the interdisciplinary team. 6. Physical Restraints shall be defined as any device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily,</p>			

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F 279 SS=D Bldg. 00	<p>thus restricting freedom of movement or normal access to one's body. 7. Order for restraint to be reviewed quarterly. Each resident who is restrained must be reassessed every three months or less as indicated and as appropriate reduction programs are begun..."</p> <p>3.1-31(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to develop resident care plans related to the risk for bruising and bleeding for a resident</p>	F 279	<p>F279 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>	03/25/2015

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	<p>taking Aspirin (a medication which can thin the blood) and Plavix (a medication which prevents the blood from clotting), for 1 of 3 residents reviewed for non-pressure skin conditions of the 6 who met the criteria for non-pressure skin conditions. (Resident #165)</p> <p>Finding includes:</p> <p>During an observation of Resident #165 on 02/17/2015 at 09:24 a.m., a dark purplish discoloration was noted to the back of the right hand. The resident indicated she was unsure how or when she got it.</p> <p>During an observation of Resident #165 on 02/18/2015 at 2:46 p.m., a dark purplish discoloration remained to the back of the right hand. The resident indicated no staff had addressed the area.</p> <p>During an observation with RN #2 on 02/18/2015 at 2:48 p.m., the dark discoloration to the back of the right hand was viewed. RN #2 indicated she was unaware of the area. RN #2 further indicated the CNAs should have noticed the discoloration during daily care and should have reported anything new to the nurse to further evaluate and investigate. Resident #165 indicated at the time of the</p>		<p>·Resident #165 had no adverse effects related to this deficiency, care plan reviewed and updated on 2/20/15</p> <p>How are residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>·All residents with anticoagulants were assessed with no adverse effects identified and care plans were updated</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur</p> <p>·In-service provided to MDS/care plan team on necessity to care plan anticoagulant therapy.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p> <p>·DHCS or designee to audit 5 records per week to ensure care plan completion and accuracy. Findings will be reported in Quality Assurance meeting monthly for 90 days or until 100% compliance is reached.</p> <p>By what date the systemic changes will be completed</p> <p>·All systematic changes will be completed by March 25, 2015</p>	

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	<p>observation she was unaware of when or how it happened. RN #2 indicated she would start documentation of the area.</p> <p>Resident #165's record was reviewed on 02/18/2015 at 2:20 p.m. Diagnoses included, but were not limited to, confusion, hypertension, anemia, hematuria (blood in the urine), cardiomegaly, atrial fibrillation (irregular heart beat), diabetes mellitus, peripheral vascular disease, peripheral arterial disease, deep vein thrombosis (blood clot), and coronary artery disease.</p> <p>Review of the February 2015 Physicians Order Summary included the following medication orders: - ASA (aspirin - a medication which can thin the blood) 81 mg (milligrams) EC (enteric coated) 1 tablet by mouth daily - Plavix (a medication which prevents the blood from clotting) 75 mg 1 tablet by mouth daily</p> <p>Review of the Medication Administration Record (MAR) for February 2015 indicated Resident #165 received the ASA and Plavix as ordered.</p> <p>The resident's record lacked a care plan addressing the bleeding and bruising risks presented by use of the medications ASA and Plavix.</p>			

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F 282 SS=D Bldg. 00	<p>Interview with the Minimum Data Set (MDS) Coordinator on 02/20/2015 at 10:48 a.m., indicated she did not usually include specific medications on care plans except Coumadin and psychotropics unless the resident had an issue. The last MDS for Resident #165 was completed on 12/24/15 and care plans were completed on 12/31/14.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure Physician's orders and care plans were followed as written related to a blood draw being completed incorrectly for 1 of 3 residents reviewed for non pressure related skin conditions of the 6 residents who met the criteria for non pressure related skin conditions. (Resident #156)</p> <p>Finding includes: Observation on 2/16/15 at 2:33 p.m., Resident #156 was laying in bed and was</p>	F 282	<p>F282 What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice? ·Resident #156 was assessed with no negative consequences. Medical alert bracelet indicating Limb alert applied to theaffected limb. How are resident shaving the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ·All residents with orders for no BP or blooddraw were assessed</p>	03/25/2015

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	<p>observed to have a blue/purple discoloration to the top of her left hand.</p> <p>Observation on 2/18/15 at 10:25 a.m., Resident #156 was sitting in her wheelchair in her room. The resident was observed to have a blue/purple discoloration to the top of her left hand.</p> <p>Record review was completed for Resident #156 on 2/18/15 at 1:26 p.m. The residents diagnoses included, but were not limited to, Alzheimer's, dementia with behaviors, paranoia, hypertension, and depression.</p> <p>The Annual Minimum Data Set (MDS) assessment completed on 12/4/14 indicated the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) of 6.</p> <p>A Care Plan indicated: Potential for fluid and electrolyte imbalance do to her having a history of edema to her bilateral lower extremities, history of refusing medications her use of a diuretic, and also for being at risk for edema do to her history of a mastectomy. An intervention indicated no blood pressures or lab draws to her left upper extremity.</p> <p>The February 2015 Physician Order Summary (POS) indicated a skin</p>		<p>with no deficiencies identified and medical alert bracelets were applied.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur</p> <ul style="list-style-type: none"> ·Lab will be notified of change to implement medical alert placement and education will be provided. Licensed nurses will bein-serviced on medical alert bracelet placement . <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p> <ul style="list-style-type: none"> ·DHCS or designee to audit 5 records/patients perweek to ensure bracelet placement and lab follow through. Findings will be reported in Quality Assurance meeting monthly for 90 days or until 100%compliance is reached. <p>By what date thesystemic changes will be completed</p> <ul style="list-style-type: none"> ·All systematic changes will be completed by March 25, 2015 	

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	<p>assessment to be completed every week and no blood draws or blood pressure to the Left Upper Extremity (LUE) do to a mastectomy.</p> <p>A Physician's Telephone Order dated 2/12/15 at 7:57 a.m., indicated a Uric Acid level to be drawn.</p> <p>A Laboratory order form dated 2/12/15 indicated a blood test was ordered for a Uric Acid level.</p> <p>Review of the Treatment Assessment Record (TAR) indicated the resident had a skin assessment completed on 2/16/15 and no new skin issues were noted.</p> <p>A shower sheet completed on 2/17/15 indicated no skin issues were observed.</p> <p>A review of Nursing Notes from 2/16/15 to 2/18/15 indicated the discoloration was not addressed or assessed until brought to the facility's attention on 2/18/15.</p> <p>An interview with RN #1 on 2/18/15 at 1:42 p.m., indicated nursing does weekly skin assessment on residents. When CNAs do any resident care they monitor skin and would report to the nurse any irregularities with the skin. Any new skin issues would be charted in Nursing Notes. The discoloration was then</p>			

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F 309 SS=D	<p>pointed out to the nurse and she indicated someone should have noticed the discoloration by now and it should have been reported. She further indicated the resident had a blood draw recently so she is going to see if the blood was drawn from the top of the left hand.</p> <p>An interview with Nursing Supervisor #1 on 2/19/15 at 2:32 p.m., indicated they had contacted the lab and the blood draw was from the top of the left hand. She indicated there was no proper procedure or policy on letting lab know if a resident had any specific restrictions on blood draws. She indicated there was no proof that lab was told not to use the left hand for the blood draw. She further indicated she just assumed the lab looked at the residents orders in the chart.</p> <p>An incident report was filled out on 2/18/15 by Nursing Supervisor #1. The report indicated: it was brought to the writers attention of a discoloration to the left posterior hand. The discoloration measures 3 cm (centimeters) x 3 cm. The report further indicated the resident had a lab draw on 2/12/15.</p> <p>3.1-35(g)(2)</p>				
	483.25 PROVIDE CARE/SERVICES FOR				

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Bldg. 00	<p>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 observation, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 2 or 3 residents reviewed for non pressure related skin conditions of the 6 residents who met the criteria for non pressure related skin conditions. (Resident #156 and #165)</p> <p>Findings include:</p> <p>1. Observation on 2/16/15 at 2:33 p.m., Resident #156 was laying in bed and was observed to have a blue/purple discoloration to the top of her left hand.</p> <p>Observation on 2/18/15 at 10:25 a.m., Resident #156 was sitting in her wheelchair in her room. The resident was observed to have a blue/purple discoloration to the top of her left hand.</p> <p>Record review was completed for Resident #156 on 2/18/15 at 1:26 p.m. The residents diagnoses included, but</p>	F 309	<p>F309 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Residents # 156 and #165 had no adverse effects related to these deficiencies and were re-assessed with findings addressed appropriately <p>How are resident shaving the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> ·All residents will be re-assessed by 3/19/15 and addressed accordingly and investigated appropriately <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur</p> <ul style="list-style-type: none"> ·Policy will be revised to include weekly assessment of non-pressure skin conditions on the TAR. Nursing staff to bere-educated on skin assessment process. <p>How the corrective action will be monitored to ensure the deficient practice will not occur</p>	03/25/2015

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	<p>were not limited to, Alzheimer's, dementia with behaviors, paranoia, hypertension, and depression.</p> <p>The Annual Minimum Data Set (MDS) assessment completed on 12/4/14 indicated the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) of 6.</p> <p>A Care Plan indicated: Potential for fluid and electrolyte imbalance do to her having a history of edema to her bilateral lower extremities, history of refusing medications her use of a diuretic, and also for being at risk for edema do to her history of a mastectomy. An intervention indicated no blood pressures or lab draws to her left upper extremity.</p> <p>The February 2015 Physician Order Summary (POS) indicated a skin assessment to be completed every week and no blood draws or blood pressure to the Left Upper Extremity (LUE) do to a mastectomy.</p> <p>A Physician's Telephone Order dated 2/12/15 at 7:57 a.m., indicated a Uric Acid level to be drawn.</p> <p>A Laboratory order form dated 2/12/15 indicated a blood test was ordered for a Uric Acid level.</p>		<p>what quality assurance program will be put in place</p> <ul style="list-style-type: none"> ·DHS or designee to audit 5 residents skin assessments for accuracy through additional or concurrent skin assessment on same day. Findings will be reported in Quality Assurance meeting monthly for 90days or until 100% compliance is reached. <p>By what date the systemic changes will be completed</p> <ul style="list-style-type: none"> ·All systematic changes will be completed by March 25, 2015 	

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	<p>Review of the Treatment Assessment Record (TAR) indicated the resident had a skin assessment completed on 2/16/15 and no new skin issues were noted.</p> <p>A shower sheet completed on 2/17/15 indicated no skin issues were observed.</p> <p>A review of Nursing Notes from 2/16/15 to 2/18/15 indicated the discoloration was not addressed or assessed until brought to the facility's attention on 2/18/15.</p> <p>An interview with RN #1 on 2/18/15 at 1:42 p.m., indicated nursing does weekly skin assessment on residents. When CNAs do any resident care they monitor skin and would report to the nurse any irregularities with the skin. Any new skin issues would be charted in Nursing Notes. The discoloration was then pointed out to the nurse and she indicated someone should have noticed the discoloration by now and it should have been reported. She further indicated the resident had a blood draw recently so she is going to see if the blood was drawn from the top of the left hand.</p> <p>An interview with Nursing Supervisor #1 on 2/19/15 at 2:32 p.m., indicated they had contacted the lab and the blood draw was from the top of the left hand. She</p>			

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	<p>indicated there was no proper procedure or policy on letting lab know if a resident had any specific restrictions on blood draws. She indicated there was no proof that lab was told not to use the left hand for the blood draw. She further indicated she just assumed the lab looked at the residents orders in the chart.</p> <p>An incident report was filled out on 2/18/15 by Nursing Supervisor #1. The report indicated: it was brought to the writers attention of a discoloration to the left posterior hand. The discoloration measures 3 cm (centimeters) x 3 cm. The report further indicated the resident had a lab draw on 2/12/15.</p> <p>2. During an observation of Resident #165 on 02/17/2015 at 09:24 a.m., a dark purplish discoloration was noted to the back of the right hand. The resident indicated she was unsure how or when she got it.</p> <p>During an observation of Resident #165 on 02/18/2015 at 2:46 p.m., a dark purplish discoloration remained to the back of the right hand. The resident indicated no staff had addressed the area.</p> <p>During an observation with RN #2 on 02/18/2015 at 2:48 p.m., the dark discoloration to the back of the right hand</p>			

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	<p>was viewed. RN #2 indicated she was unaware of the area. RN #2 further indicated the CNAs should have noticed the discoloration during daily care and should have reported anything new to the nurse to further evaluate and investigate. Resident #165 indicated at the time of the observation she was unaware of when or how it happened. RN #2 indicated she would start documentation of the area.</p> <p>Resident #165's record was reviewed on 02/18/2015 at 2:20 p.m. Diagnoses included, but were not limited to, confusion, hypertension, anemia, hematuria (blood in the urine), cardiomegaly, atrial fibrillation (irregular heart beat), diabetes mellitus, peripheral vascular disease, peripheral arterial disease, deep vein thrombosis (blood clot), and coronary artery disease.</p> <p>Review of the Weekly Skin sheet dated 2/16/15 indicated no skin issues.</p> <p>Review of the Treatment Administration Records (TARs) for February 2015 indicated a lack of documentation of a discoloration to the back of the right hand.</p> <p>Review of the Nurses' Notes from 2/7/15 to 2/17/15 indicated a lack of documentation of a discoloration to the</p>			

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	<p>back of the right hand.</p> <p>A Nurses' Note dated 2/18/15 at 3:00 p.m. by RN #2 indicated, " skin warm dry, bruise to R (right) top of hand, 3 x 3 cm, pt (patient) denies pain or discomfort, skin intact, no open areas noted, NP (Nurse Practitioner) notified, no new orders"</p> <p>Review of the February 2015 Physicians Order Summary included the following medication orders:</p> <ul style="list-style-type: none"> - ASA (aspirin - a medication which can thin the blood) 81 mg (milligrams) EC (enteric coated) 1 tablet by mouth daily - Plavix (a medication which prevents the blood from clotting) 75 mg 1 tablet by mouth daily <p>Review of the Medication Administration Record (MAR) for February 2015 indicated Resident #165 received the ASA and Plavix as ordered.</p> <p>Interview with LPN #2 on 02/18/2015 at 2:21 p.m. indicated if a bruise was noted, nurses would check the current charting to see if it was new, then would document it on the back of a treatment sheet. She further indicated the area would be followed in the Nurses' Notes for three days.</p>						

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F 329 SS=D Bldg. 00	<p>On 2/18/15 at 2:15 PM, the ADON presented a facility policy regarding pressure-related skin areas, but indicated there was no policy specific to non-pressure skin monitoring.</p> <p>3.1-37(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a resident's drug regimen remained free of unnecessary medications related to the lack of side effect monitoring and a</p>	F 329	<p>F329 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Resident # 67 was assessed</p>	03/25/2015

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	<p>timely Dyskinesia Identification System - Condensed User Scale (DISCUS) assessment completed for a resident receiving psychotropic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #67)</p> <p>Finding includes:</p> <p>The record for Resident #67 was reviewed on 02/19/2015 at 8:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and paralysis agitans (Parkinson's disease).</p> <p>Review of the February 2015 Physician's Order Summary (POS) indicated the following psychoactive medication orders:</p> <ul style="list-style-type: none"> - Seroquel (antipsychotic) 12.5 mg (milligrams) per half tab by mouth every morning - Seroquel 25 mg 1 tablet by mouth at bedtime - Buspar (antidepressant) 5 mg 1 tablet by mouth 3 x (times) daily <p>Review of the January and February 2015 Medication Administration Records (MARs) indicated the medications had been given as ordered. The MARs lacked documentation to indicate monitoring of the side effects of the</p>		<p>utilizing the DISCUS resident had no adverse effects related to medication use.</p> <p>How are resident shaving the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> ·All residents on anti-psychotic medications were assessed to ensure DISCUS was completed, no deficiencies identified. <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur</p> <ul style="list-style-type: none"> ·Facility will begin utilizing AIMS form in place of DISCUS. MDS/ Care plan team to be in serviced on use of AIMS assessment tool will complete on a semi-annual basis per policy and MDS schedule <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p> <ul style="list-style-type: none"> ·DHCS or designee to audit 5 records per week to ensure completion of anti-psychotic side effects assessment tool. Findings will be reported in Quality Assurance meeting monthly for 90 days or until 100% compliance is reached. <p>By what date the systemic changes will be completed</p> <ul style="list-style-type: none"> ·All systematic changes will be completed by March 25, 2015 	

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	<p>psychoactive medications was done.</p> <p>DISCUS assessments were completed on 4/9/14 and 8/15/14. The record lacked documentation of a DISCUS assessment completed since 8/15/14.</p> <p>The clinical record indicated Resident #67 was readmitted to the facility on 12/24/14 after a hospital stay for a significant change in health status.</p> <p>A care plan for psychotropic drugs included, but was not limited to, the following intervention, " Provide medications per MD orders, update MD to any ill effects noted"</p> <p>Interview with the Social Services Director (SSD) on 02/19/2015 at 10:00 a.m., indicated the facility staff were doing DISCUS assessments quarterly for residents and were told by their corporate it was only needed every six months. Staff did not do one upon readmission from the hospital and one had not been done since 8/15/14. She further indicated she believed the assessment cycle would not be restarted with a new admission but did indicate it was past six months at this point since the last DISCUS assessment was completed and one should have been done.</p>			

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F 371 SS=E Bldg. 00	<p>Follow up interview with the SSD on 02/19/2015 11:02 a.m., indicated the monitoring of side effects should be done by the nurses and documented on the MARs, which usually had a line under the medication for the nursing staff to fill out.</p> <p>Interview with LPN #1 on 02/23/2015 at 12:39 p.m., indicated if a resident was taking a medication requiring side effect monitoring such as a psychoactive medication, there was a separate line on the MAR to be used by nursing for documentation.</p> <p>Interview with the ADON on 02/23/2015 at 12:47 p.m., indicated monitoring of medication side effects was done for a little while in the nurses' notes if a new medication was started, but day to day monitoring should be charted on the MAR under the medication. She further indicated Resident #67 should have had this documented on the MAR and she was unsure why it was not done.</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or</p>			

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	<p>considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, and interview, the facility failed to distribute food under sanitary conditions related to fluids uncovered during serving of the 200 and 700 hallway room trays. This affected 2 of 3 hallways observed for room tray distribution. (200 and 700 Hallway Cart)</p> <p>Finding includes:</p> <p>During an observation of lunch service on 2/19/15 at 11:55 a.m. on the 700 Hallway, Nursing Supervisor #1 poured coffee from a carafe from the tray cart, placed the cup on a lunch tray, and carried the tray with the uncovered drink down the hallway to Room 712.</p> <p>During the same lunch service observation on 2/19/15 at 11:57 a.m. on the 200 Hallway, CNA #1 poured hot water from a carafe from the tray cart, placed the cup on a lunch tray, and carried the tray with the uncovered drink down the hallway to Room 212.</p> <p>Interview with Nursing Supervisor #1 on 2/19/15 at 12:00 p.m., indicated it was not standard practice to leave the fluids uncovered, and the beverage should have been covered with a lid.</p>	F 371	<p>F371 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> All residents who eat in their rooms had the potential to be affected by the alleged deficient practice. Room trays now have lids covering hot and cold beverages as of 2/19/15. <p>How are residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <ul style="list-style-type: none"> All residents who eat in their room have the potential to be affected by the alleged deficient practice. Room trays now have lids covering hot and cold beverages as of 2/19/15. <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur</p> <ul style="list-style-type: none"> Policy was created and implemented on 2/19/15. All Culinary and Nursing staff have been in-serviced on citation and new policy as of 2/19/15. <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p>	03/25/2015

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F 441 SS=D Bldg. 00	<p>Interview with CNA #1 on 2/19/15 at 12:02 p.m., indicated that was not common practice, the beverages should have been covered.</p> <p>Interview with the Culinary Services Director on 2/19/15 at 1:15 p.m., indicated it was common practice for room trays to be distributed with uncovered beverages. He further indicated there was not a current policy and the beverages should have been covered on the room trays.</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p>		<p>· Culinary Director or designee will ensure new policy compliance. Visual inspection will be added to audit form. Audit to be completed 5 days per week for 90 days or until 100% compliant. Findings will be reported in QA meeting monthly for 90 days or until 100% of compliance is completed.</p> <p>By what date the systemic changes will be completed</p> <p>· All systematic changes will be completed by March 25, 2015</p>	

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to administer a Influenza vaccine as ordered for 1 of 5 residents reviewed for infection control and immunizations. (Resident #64)</p> <p>Finding includes:</p> <p>Resident #64's record was reviewed on 2/20/15 at 10:00 a.m.</p> <p>The "Resident/Client Vaccine Consent Form" indicated the Influenza vaccine was wanted. The form had a handwritten "verbal yes 12/11/14" and was initialed by the floor nurse.</p> <p>The "Influenza Vaccination Record"</p>	F 441	<p>F441 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Resident #64 had flu vaccine offered again on February 25 and it was refused. Resident has no adverse effects related to flu vaccine not being administered</p> <p>How are resident shaving the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>·All residents with consent for a flu vaccine were assessed for administration of vaccine, no deficiencies identified</p> <p>What measure will be put into place or what systemic changes will be made to</p>	03/25/2015

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	<p>lacked documentation to indicate the vaccine had been given.</p> <p>The resident's Nurse Progress notes dated 12/2/14 through 2/2/15 were reviewed and indicated the Influenza vaccine was not given.</p> <p>The Medication Administration Record and the Treatment Administration Record for December 2014, January 2015 and February 2015 were reviewed and indicated the Influenza vaccine was not given.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 2/20/15 at 10:23 a.m., indicated the influenza vaccine should have been given, since the consent had verbal consent written on it and dated 12/11/14.</p> <p>Interview with the DON (Director of Nursing) on 2/23/15 at 2:37 p.m., indicated the resident's Physician's Order upon admission was the standing order for the yearly Influenza vaccine, unless refused or contraindicated. The way it was written on the current Physician's Order Summary was equivalent to the yearly Physician's Order.</p> <p>A policy titled "Influenza and Pneumoccal Immunizations," was</p>		<p>ensure that the deficient practice does not re-occur</p> <ul style="list-style-type: none"> ·Licensed staff will be re-in serviced on fluvaccine policy and consents and administration.. <p>How the corrective action will be monitored to ensure the deficient practice will not occur what quality assurance program will be put in place</p> <ul style="list-style-type: none"> ·DHCS or designee to audit 5 records per week to ensure flu vaccine administration. Findings will be reported in Quality Assurance meeting monthly for 90 days or until 100% compliance is reached. <p>By what date the systemic changes will be completed</p> <ul style="list-style-type: none"> ·All systematic changes will be completed by March 25, 2015 	

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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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F 465 SS=E Bldg. 00	<p>provided by the Director of Nursing on 2/16/15 at 1:00 p.m., as current and indicated, "...Procedure: 3.3 The resident or their legal representative will either sign for approval or refusal of the influenza and pneumococcal immunization...."</p> <p>3.1-5</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the resident's environment was clean and in good repair related to marred and gouged walls, closet doors and door frames, cracked caulk around sinks and stained bathroom pull cords for 7 of 7 Hallways. (100-200-300-400-500-600 and 700 Hallways)</p> <p>Findings include:</p> <p>During the Environmental Tour on 2/21/15 at 1:55 p.m., with the Director of Maintenance, the Administrator and the Assistant Administrator, the following was observed:</p>	F 465	<p>F465 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·All resident rooms in the entire building have been reviewed for marred and gougedwalls and doors. Rooms were alsoinspected for cracked calking, and soiled call cords. Gouged walls and doors for those residentsaffected by the alleged deficient practice have been corrected and repaired.</p> <p>How are residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken.</p> <p>·Allresidents have the potential to be affected by the alleged deficient practice. Vinyl call cord</p>	03/25/2015

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	<p>1. 100 Hallway:</p> <p>a. In Room #111, the bathroom pull cord was stained brown, the bathroom ceiling over the sink had a brown stain, the closet door frame had gouges and the wall behind the recliner was gouged. There was one resident who resided in this room.</p> <p>b. In Room #112, the bathroom pull cord was stained brown and there was cracked caulk around the sink. There was one resident who resided in this room.</p> <p>2. 200 Hallway:</p> <p>a. In Room #201, the closet doors and frame were marred. There were two residents who resided in this room.</p> <p>b. In Room #202, the inside and the outside of the bathroom doorframe was marred, the toilet riser seat handles were rusty and the pull cord was stained brown. There were two residents who resided in this room.</p> <p>c. In Room #205, the heater register vent was bent, the wall was gouged between the bed and the window, the bathroom pull cord was stained brown and the caulk around the sink was cracked. There were two residents who resided in</p>		<p>material has been specialordered along with acrovyn for doors. Maintenancestaff while performing preventative maintenance rounds will note any potential deficientenvironmental conditions.</p> <p>What measure will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not re-occur</p> <ul style="list-style-type: none"> ·Allrooms will be inspected upon all admissions and discharges for deficientenvironmental conditions. Additionally, weeklymaintenance audit rounds will be reviewed by Maintenance Director anddocumented on audit sheets. <p>How thecorrective action will be monitored to ensure the deficient practice will notoccur what quality assurance program will be put in place</p> <ul style="list-style-type: none"> · Findings will be reported to Quality Assurancemeetings monthly for 90 days or until compliance is 100%. <p>By what date the systemic changeswill be completed</p> <ul style="list-style-type: none"> ·Allsystematic changes will be completed by March 25, 2015 	

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	<p>this room.</p> <p>d. In Room #207, the bathroom pull cord was stained brown, and the cove base was gouged in the bathroom. There was one resident who resided in this room.</p> <p>e. In Room # 211, the closet door frame was gouged and there was a cracked bathroom floor tile behind the toilet. There were two residents who resided in this room.</p> <p>f. In Room #216, the closet door frame was gouged and there was loose cove base by the closet. There was one resident who resided in this room.</p> <p>3. 300 Hallway:</p> <p>a. In Room #301, the caulk around the sink was cracked, the inner bathroom door was gouged, the bathroom pull cord was stained yellow, the closet door and frame was gouged. There were two residents who resided in this room.</p> <p>b. In Room #302, the bathroom walls were marred, there was a missing flange bowl cap at the toilet base, and the closet door and frame was gouged. There were two residents who resided in this room.</p> <p>c. In Room #303, the frame around the</p>			

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	<p>closet door was gouged and the outside bottom of the room door was marred. There were two residents who resided in this room.</p> <p>d. In Room #310, the inside tracking of the closet door was splintered, the wall beside the closet and closet frame were gouged and the bathroom walls were gouged. There were two residents who resided in this room.</p> <p>4. 400 Hallway:</p> <p>a. In Room #414, the bathroom wall had a large gouged area. There were two residents who resided in this room.</p> <p>5. 500 Hallway:</p> <p>a. In Room # 504, the bathroom walls were gouged, the closet frame was gouged, and there was chipped paint on the bottom of the wall next to the closet. There was one resident who resided in this room.</p> <p>b. In Room #506, the inside, bottom of the bathroom door was gouged, the wall next to the bathroom was gouged, there was chipped paint on the bottom of the bathroom door frame and the corner of the walls. There was one resident who resided in this room.</p>			

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	<p>c. In Room #509, the bathroom door frame and the bottom corner of the wall next to the closet had chipped paint. There were two residents who resided in this room.</p> <p>d. In Room # 511, the bottom inside bathroom door and the closet frame were gouged and the bottom corner of the wall next to the closet had chipped paint. There were two residents who resided in this room.</p> <p>e. In Room #512, the inside bottom of the bathroom door was gouged. There was one resident who resided in this room.</p> <p>f. In Room #514, the inside bottom of the bathroom door was gouged, and the bathroom wall had holes. There was one resident who resided in this room.</p> <p>6. 600 Hallway:</p> <p>a. In Room #608, the inside, bottom of the bathroom door was gouged, and there was chipped paint on the bottom corner of the wall by the closet. There were two residents who resided in this room.</p> <p>b. In Room #609, the walls were marred, there was chipped paint on the corners of</p>			

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	<p>the wall next to the bathroom and closet, marred and gouged walls in the bathroom. There was one resident who resided in this room.</p> <p>c. In Room #613, the inside bottom of the bathroom door was gouged and there were black marks on the floor next to one of the resident's beds. There were two residents who resided in this room.</p> <p>d. In Room #614, there was chipped paint on the bottom corner of the wall next to the bed side chair. There were two residents who resided in this room.</p> <p>e. In Room #616, the closet frame had gouges and the paint was chipped on the bottom corner of the wall next to the closet. There were two residents who resided in this room.</p> <p>7. 700 Hallway:</p> <p>a. In Room #704, the bathroom door was gouged and the bathroom pull cord was stained brown. There were two residents who resided in this room.</p> <p>b. In Room #713, the bathroom cove base had gaps in the corners, the bathroom pull cord was stained brown and the closet door had gouges. There was one resident who resided in this</p>			

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	room. Interview with Director of Maintenance indicated all repairs needed to be completed. 3.1-19(f)				