STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALET VILLAGE HEALTH AND REHABILITATION CENTER	1065 PARKWAY ST BERNE, IN 46711

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 30 and 31, August 1, 4, 5 and 6, 2014 Facility number: 000546 Provider number: 155473 AIM number: 100267370 Survey team: Julie Call, RN Sue Brooker, RD Virginia Terveer, RN Martha Saull, RN (July 31, August 1, 4, 5 and 6, 2014) Census bed type: SNF/NF: 33 Total: 33 Census payor type: Medicare: 5 Medicaid: 21 Other: 7 Total: 33 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on	F000000	Submission of this plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	

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

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

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	August 11, 2014 by Randy Fry RN.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Base on interview and record review, the facility failed to ensure the physician was	F000157	1. Resident#14 physician was notified immediately of the significant wt. loss.	09/05/2014

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	notified of a resident's significant weight loss for 1 of 4 resident's reviewed for weight loss. (Resident #14) Findings include: The clinical record of Resident #14 was reviewed on 8/4/14 at 10 A.M. Diagnoses included, but were not limited to, the following: depression, dementia with delusions and status post fixation of left hip fracture. The MDS (Minimum Data Set) assessment dated 6/26/14 included, but was not limited to, the following: independent in cognition; eating required supervision, overweight, encouragement and/or cueing; height of 68 inches and weight of 118 lb; weight loss of 5% or more in the last month was "no." A "Nutritional Progress note" dated 6/23/14 included, but was not limited to, the following: "RD (registered dietician) review of wt (weight)/hosp (hospitalization) rtn (return). Current wt = 117.8 lb (6/17/14), sig (significant) wt loss at 9.7% x 30 days. PO (oral) 25-50%; not taking fluids well...cognitive decline per staff. Note admit wt (weight) of 174 # was incorrect. Actual admit wt = 130.4 lbs. Rec: (recommend) super cereal with breakfast...4 oz shake tid (three times a day) between meals. Rec		Dietaryrecommendations reviewed with physician and orders obtained. 2. Chartaudits completed for the past 3 months, to assure proper physician notificationof significant wt loss and to assure dietary recommendations had been addressedpromptly. 3. In an effort to ensure ongoing compliance withphysician notification of significant weight loss, nursing staff werere-educated on physician notification of significant wt. loss and theimportance of prompt follow up of dietary recommendation. Following said education and in an effort tomonitor for compliance, the DON and /or her designee will audit residentsrecords of those residents whose weights were obtained during each week on aweekly basis times 4 weeks to determine ongoing compliance with monitoringresident weights, identifying significant weight change, conducting re-weightsas necessary, and notification of physician of significant weight loss, as wellas of dietary recommendations. Monthly monitoring shall occur ongoingthereafter. Should concerns be noted during the aforementioned audits, immediatecorrective action(s) shall be taken. 4. The DON and/or designee will report findings ofthese audits and any corrective actions taken	

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	D/C (discontinue) 2 P.M. snack." A "...Dietary Progress note" dated 7/25/14 included, but was not limited to, the following: "Usual body weight" was left blank; height 63 inches, current weight 115.4 lb and weight 1 month ago was 118.8 lb, 3 months ago was 130.4 lb; Explain changes: "sig (significant) wt (weight) loss since admission." Current diet order was pureed; Supplements: 2 P.M. snack. On 8/4/14 at 11:30 A.M. the following weights were observed documented in the facility weight book: documented in the upper right hand corner of the form, the initial weight on 5/28/14 was 130.4 lb on admission. Documented on the calendar grid portion of the form was the following: 5-28-14 indicated a weight of 174 lb. that had been crossed out and a weight of 130.4 documented over it. The weight of 130.4 was not dated as to when the revision was made. The next weights (in pounds) were as followed: 6/4: 124.8 6/4: 124.8 6/10: 118.8 6/17: 117.8 6/26: 115.8 7/1: 115.2 On 8/5/14 at 9:15 A.M., the		to the QA committee monthly x 3months and quarterly thereafter, and revisions made to the plan (e.g.,frequency of monitoring increased should non-compliance be identified ordecreased should consistent compliance be identified) if warranted.	

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	Administrator (ADM), Director of Nursing (DON) and the RN Consultant were interviewed. They indicated the following: The ADM indicated the new residents are on the SWAT (Skin weight assessment tool) every other week. The DON indicated they are weighed weekly for the first month. On 8/5/14 at 9:15 A.M., the ADM (Administrator), DON (Director of Nursing) and RN Consultant were interviewed. They indicated they were unable to locate documentation the physician had been notified of the resident's significant weight loss of 130.4 lbs on 5/28/14 to 118.8 lbs on 6/10/14, a loss of 8.8%; and/or a 4.8% loss from 6/4/14, weight of 124.8 lb to a weight of 118.8 lbs on 6/10/14. On 6/17/14, the resident's weight was 117.8 lbs, down from 130.4 on 5/28/14 or a 9.6% weight loss. On 8/5/14 at 9:50 A.M., the DON provided a copy of the facility policy and procedure for "Nutrition and Weight Loss Management Program", dated 10/05. This policy included, but was not limited to, the following: "...Physician and family notification will be made with significant weight loss or gain: 30 days = 5%; 3 months = 7.5% and 6 months = 10%..."			

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	On 8/5/14 at 4:15 P.M., the RN consultant was interviewed. She indicated they were unable to provide documentation the physician had been notified of the significant weight loss. 3.1-5(a)(2)			
F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review the facility failed to ensure 4 residents (Resident #5, Resident #34, Resident #8 and Resident #3) were treated in a dignified manner when eating their meals in the dining room during 4 of 4 meal observations. Findings include: 1. During an observation of the lunch meal in the dining room on 7/30/14 the following was observed:	F000241	1. Through interview and assessment, there were nonegative affects for residents #5, 34, 8, and 3. C.N.A.'s #1, 2, and 21, LPN #7, and thedietary staff were immediately re-educated concerning resident dignity. 2. All residents have the potential to be affected.All staff have been re-educated on resident rights and dignity, particularly asrelated to meal service. The Social Service designee has interviewed allresidents to assure they feel that they are treated with dignity, with nonegative results. 3. As a means to ensure	09/05/2014

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	- At 12:00 p.m., Resident #5 requested a second plate of the alternate entree served. Certified Nursing Assistant (CNA) #1 was observed to use her key to open the door into the kitchen and ask staff in the kitchen for an extra plate of food for Resident #5. - At 12:11 p.m., Resident #5 was observed to leave the dining room. He did not receive the extra plate of food he requested and no staff informed him it was not available or he could not have it. Resident #5 was interviewed on 7/30/14 at 12:16 p.m. During the interview he indicated he did not receive the extra food he had requested. He also indicated he felt he had been forgotten so he just left the dining room. The Dietary Manager was interviewed on 8/6/14 at 9:05 a.m. During the interview she indicated residents who ask for additional food were to receive it unless there were dietary restrictions. If a resident was on a restricted diet, staff were to educate the resident on why they should not have the extras, but if the resident still decided to have the extras they would be provided. She also indicated if a resident asked for more food but did not receive it, there was a breakdown in communication between		ongoing compliance withtreating residents in a dignified manner during meals, all staff have been re-educatedon resident rights and dignity. The Social Service designee has interviewed allresidents to assure they feel that they are treated with dignity, with nonegative results. The Social Service Designee and/or her designee willinterview residents monthly x 3 months, then at least 3 random residents monthlythereafter. The Administrative staffwill monitor meals 5 days per week x 4 weeks at varied meals, then weekly x 4weeks and monthly thereafter, to assure residents are being treated with dignityduring meal times.Should concerns be noted during the aforementionedinterviews/observations, corrective actions shall be taken. 4. As a means of quality assurance, the SocialServices designee and the Administrator and/or their designee will report the resultsof the aforementioned interviews, observations and any corrective actions takento the QA committee monthly x 3 months and quarterly thereafter, and revisionsmade to the plan (e.g., frequency of monitoring increased or decreased) ifwarranted.	

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	the dining room and the kitchen. 2. During an observation of the lunch meal in the dining room on 7/31/14 the following was observed: - At 11:43 a.m., beverage service had started in the dining room. Resident #34 and a family member were observed seated at a dining room table. Clothing protectors had already been placed on the tables for those residents who wore them during dining. CNA #1 was pushing a beverage cart through the dining room going from table to table to serve those residents already in place in the dining room. She was observed to serve beverages to a resident at the table next to Resident #34, making Resident #34 the next resident to be served. At 11:46 a.m., another resident was observed to enter the dining room and be seated at a table on the opposite side of the dining room as Resident #34. CNA #1 then pushed the beverage cart toward the resident who just entered the dining room without serving Resident #34. The family member was observed to make a gesture with his hands and arms to indicated his confusion on why resident #34 had not been the next resident served. At 11:51 a.m., he was observed to ask CNA #1 for a beverage for Resident #34. Hot chocolate for Resident #34 was provided			

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	in a regular drinking mug. The family member of Resident #34 had to ask CNA #1 for a flow control cup which resident #34 was to use to drink her beverages. He was then observed to ask CNA #1 for a clothing protector for her. The family member of Resident #34 was interviewed on 8/4/14 at 11:30 a.m. During the interview he indicated he did not know why staff did not serve Resident #34 a beverage until he requested. He also indicated he had to request her beverage be changed into a flow control cup since she was unable to drink from a regular mug. He further indicated she always wore a clothing protector during meals. 3. During an observation of the lunch meal in the dining room on 8/4/14 the following was observed: - At 12:03 p.m., Resident #8 was observed seated in her wheelchair at a dining room table with another resident.. She was observed to push her plate of food away from her. CNA #2 was observed to sit next to Resident #8 to encourage her to eat, even asking if she would like something else. Resident #8 indicated she was not hungry. LPN #7 was then observed to come to Resident #8's table as well. At that time, CNA #2			

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	was observed to pick up a bowl containing ground meat served to Resident #8 and made the comment to LPN #7 she did not know what was in the bowl that was served to Resident #8, but she would not eat it either. Her comment was made in front of the 2 residents seated at the table. The Administrator and the Corporate Nurse RN were interviewed on 8/6/14 at 8:49 a.m. During the interview they indicated staff should never make negative comments about the food in front of the residents.			
F000325 SS=D	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. Base on observation, interview and record review, the facility failed to ensure a resident who experienced significant weight loss was provided recommended supplements in a timely manner for 1 of 4 resident's who met the criteria for weight loss. (Resident #14)	F000325	1. Thedietary recommendation for resident #14 was immediately received and initiated. 2. All Dietary recommendations were reviewed forthe past three months to assure recommendations were communicated to theattending physician, and orders received	09/05/2014

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	Findings include: The clinical record of Resident #14 was reviewed on 8/4/14 at 10 A.M. Diagnoses included, but were not limited to the following: depression, dementia with delusions and status post fixation of left hip fracture. The MDS (Minimum Data Set) assessment dated 6/26/14 included, but was not limited to the following: independent in cognition; eating required supervision, oversight, encouragement and/or cueing; height of 68 inches and weight of 118 lb; weight loss of 5% or more in the last month was "no." An "Admission Nursing Assessment" dated 5/28/14 indicated the resident was 5 feet 8 inches tall (68 inches) and weighted 174 lbs (pounds). A "Nutritional Assessment Form" dated 5/30/14 indicated the resident was 63 inches tall and had an admission weight of 174 lbs. The height of 63 inches was observed to have the notation "hosp (hospital)" beside it. The IBW (ideal body weight) range was documented as 115 pounds plus or minus 10%. Supplement ordered was a 2 P.M. snack. BMI (body mass index) indicated was 31 and would be considered as "Obese."		and initiated timely. No other irregularities were noted. 3. In an effort to ensure ongoing compliance withthe provision of supplements in a timely manner, all licensed nursing staffwere re-educated on the importance of follow through of Dietary Recommendationsto assure proper nutritional status. The DON and/or designee will audit alldietary recommendations to assure proper follow through with physician andorders received and initiated timely. Should concerns be noted during theseaudits, corrective actions shall be taken. 4. As a means of quality assurance, the DON and/ordesignee will report the findings of these ongoing audits to the QA committeemonthly x 3 months and quarterly thereafter, and revisions made to the plan ifwarranted.	

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	Note from 5/30/14: "Initial Review was "here for rehab (rehabilitation)...po (by mouth) 50%...edema to ankle, BMI =obese..." A physician order, dated 6/17/14 indicated the following: "recommend resident diet be changed to puree..." A "Nutritional Progress note" dated 6/13/14 included the following: "Hosp (hospital)." A "Nutritional Progress note" dated 6/23/14 included, but was not limited to, the following: "RD (registered dietician) review of wt (weight)/hosp (hospitalization) rtn (return). Current wt = 117.8 lb (6/17/14), sig (significant) wt loss at 9.7% x 30 days. PO (oral) 25-50%; not taking fluids well...cognitive decline per staff. Note admit wt (weight) of 174 # was incorrect. Actual admit wt = 130.4 lbs. Rec: (recommend) super cereal with breakfast...4 oz shake tid (three times a day) between meals. Rec D/C (discontinue) 2 P.M. snack." A physician order dated 6/24/14 indicated the following: "Discontinue 2 P.M. snack. Start 4 oz. shakes tid (three times a day) between meals..." A plan of care, dated 7/9/14 for			

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	"Alteration in Nutritional...status" included but was not limited to, the following: house shakes tid, pureed texture; set up with meal. A "...Dietary Progress note" dated 7/25/14 included, but was not limited to, the following: "Usual body weight" was left blank; height 63 inches, current weight 115.4 lb and weight 1 month ago was 118.8 lb, 3 months ago was 130.4 lb; Explain changes: "sig (significant) wt (weight) loss since admission." Current diet order was "pureed; Supplements: 2 P.M. snack. " This 2 P.M. snack had been recommended to be discontinued in the 6/23/14 "Nutritional Progress note." On 8/4/14 from 9:45 A.M. to 11:25 A.M. , the resident was observed in her room in her recliner with no supplement shake observed in her room. At 11:25 A.M., the resident was observed to be assisted to her wheelchair and pushed to the dining room for lunch. On 8/4/14 at 11:30 A.M. the following weights were observed documented in the facility weight book: documented in the upper right hand corner of the form, the initial weight on 5/28/14 for Resident #14 was 130.4 lb on admission. Documented on the calendar grid portion of the form was the following: 5-28-14			

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	indicated a weight of 174 lb. that had been crossed out and a weight of 130.4 documented over it. The weight of 130.4 was not dated as to when the revision was made. The next weights (in pounds) were as followed: 6/4: 124.8 6/4: 124.8 6/10: 118.8 6/17: 117.8 6/26: 115.8 7/1: 115.2 7/1: 115.2 7/8: 115.4 7/16: 116 7/30: 118.4 8/1: 118.4 On 8/4/14 at 4:50 P.M., the resident was observed to be sitting in her recliner at her bedside with the 1/2 full carton of supplement shake she had received at 2 P.M. On 8/4/14 at 5 P.M., the current MAR (medication administration record) was reviewed. This indicated "2 P.M. snack." This 2 P.M. snack had been recommended to be discontinued in the 6/23/14 "Nutritional Progress note." On 8/4/14 at 5:05 P.M. a physician order dated 6/24/14 was reviewed. The order indicated the following: "Discontinue			

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	2:00 P.M. snack. Start 4 oz (ounce) Shakes tid (three times a day) between meals..." Documentation was lacking on this order of physician signature and or clarification of it being a verbal order and/or phone order. Documentation indicated the signature of nurse receiving the order was a registered nurse (unable to read name). A care plan, dated 8/4/14, addressed the following problem: "...resident requires up to one - two assist in performing ADL (activities of daily living) due to...poor coordination, cognitive loss, lethargy..." On 8/5/14 at 9:15 A.M., the Administrator (ADM), Director of Nursing (DON) and the RN Consultant were interviewed. They indicated the following: when the admission weight of 170.4 lb was corrected to 130.4 lbs, there was no date to indicate when this weight was changed. The ADM indicated the new residents are on the SWAT (Skin weight assessment tool) every other week. The DON indicated they are weighed weekly for the first month. They indicated the CNAs document the weights. Documentation from the Dietician indicated the resident was to get snacks at three times a day. They indicated the resident gets snacks from the Dietary department and the CNAs			

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	(certified nursing assistants) deliver them to the residents. They indicated the snacks were documented on the MARS (medication administration record), if they were ordered snack, like the mighty shakes. After the current MAR was reviewed, they indicated the shakes which were to be given three times a day were not on the MAR but the 2 P.M. snacks were still on the MAR. At the time, the following was reviewed: the "Comprehensive Physician's Order Sheet " was dated 6/24/14 and indicated the following "Discontinue 2 P.M. snack, start 4 oz (ounce) shakes tid (three times a day) between meals..." Documentation was lacking on this order of a physician signature and/or the method in which the order was obtained, for example verbal order and/or telephone order. The 2 P.M. snacks had been discontinued. At the time, the ADM, DON and RN Consultant indicated they were unable to locate documentation the physician had been notified of the resident's significant weight loss of 130.4 lbs on 5/28/14 to 118.8 lbs on 6/10/14, a loss of 8.8%; and/or a 4.8% loss from 6/4/14, weight of 124.8 lb to a weight of 118.8 lbs on 6/10/14. On 6/17/14, the resident's weight was 117.8 lbs, down from 130.4 on 5/28/14 or a 9.6% weight loss.			

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	On 8/5/14 at 9:50 A.M., the DON provided a copy of the facility policy and procedure for "Nutrition and Weight Loss Management Program", dated 10/05. This policy included, but was not limited to, the following: "...Dietary staff will interview the resident and/or family to determine prior...weight history...resident's Health Care plan will address acute and on-going nutritional and weight concerns...Physician and family notification will be made with significant weight loss or gain: 30 days = 5%; 3 months = 7.5% and 6 months = 10%...The Registered Dietician will assess new admissions...on each visit..." On 8/5/14 at 11 A.M., the Administrator (ADM) provided a copy of the SWAT record for the resident. The form included, but was not limited to, the following: 5/30/14: current weight was documented as 130.4 lb; 6/13/14: weight 118.8 lb, poor appetite - 25% or meals, having increased confusion - UTI (urinary tract infection); 6/23/14: weight 117.8 lb, increased confusion. "Current Recommendations: 6/23/14: Shakes 3 x day x (between meals) - pureed diet." On 8/5/14 at 4:15 P.M., the RN consultant was interviewed. She indicated they were unable to provide documentation the physician had been			

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	notified of the significant weight loss. 3.1-46(a)(1) 3.1-46(a)(2)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F000329	1. Resident # 13's physician was notifiedimmediately and	09/05/2014

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	Based on interview and record review, the facility failed to ensure resident behaviors, moods, and/or medication doses were monitored and documented adequately for 2 of 5 residents reviewed for behaviors and moods while receiving antipsychotic or antidepressant medications. (Resident #13, Resident #11) Findings include: 1. On 7/31/14 at 10 A.M., the clinical record of Resident #13 was reviewed. Diagnoses included, but were not limited to, the following: Dementia with delusions, psychosis, anxiety, senile dementia with delirium and vascular dementia with behaviors. The MDS (Minimum Data Set) Assessment dated 5/13/14, included, but was not limited to, the following: modified independent cognition skills; signs and symptoms of delirium were disorganized thinking which was present continuously, doesn't fluctuate; no psychosis; rejection of care was none and physical, verbal and behaviors affecting others were "none." A plan of care, dated 5/15/14, which addressed the problem of "...requires use of an anti psychotic medication: Risperdal to treat Alzheimer's type dementia with psychosis...Interventions:		order was changed. C.N.A. #20 and LPN #20 were immediatelyre-educated on the importance of following the Mood and Behavior program. Resident # 11's physician was notified withno new orders as the resident had pain issues to consider along with thedepression. Resident #11 care plan wasupdated and staff were re-educated concerning the Mood and Behavior Program. 2. The records of those residents with ordered antipsychoticmedications and anti depressant medications were reviewed to assure proper useof medication (i.e., not used in excessive doses, without adequate indications,adequate monitoring). No other irregularities noted. Staff re-educated on theMood and Behavior program. 3. In an effort to ensure ongoing compliance withmonitoring of resident moods, behaviors, and mediation dosages, DON and/ordesignee will monitor new orders on scheduled days of work to assure properdosage of medication is not exceeded with dosage increase. The Social ServiceDirector will monitor mood and behavior records daily on scheduled days of workto assure proper documentation is acquired for residents with antipsychotic medications,and anti depressant medications. Shouldconcerns be noted during these audits, corrective actions shall be taken.	

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	observe for changes in mood or behavior; notify the charge nurse of noted problems for further evaluation and possible physician...notification; refer to psychological evaluation as indicated..." A plan of care, dated 5/15/14, which addressed the problem of "...suffers from the progressive cognitive and communicative deficits associated with Alzheimer's Disease with psychosis/anxiety; resists care, yells out, disorganized thinking..." Interventions included, but were not limited to, the following: "...monitor for changes in status and notify physician and responsible party as indicated..." A plan of care, dated 5/15/14, which addressed the problem of "...resident has hallucinations...believes people are in her room. Res (resident) hears voices talking to her...Interventions:...Document in detail about the hallucination and what approached (sic) worked and did not work..." A plan of care, dated 5/15/14, which addressed the problem of "...exhibits verbal behavioral symptoms directed towards others such as screaming at others, cursing at others...Interventions:...try to identify the immediate cause..."		4. As a means of quality assurance, the DON and/ordesignee, and the Social Service Director and/or designee will report thefindings of these audits and any corrective actions taken to the QA committeemonthly x 3 months and quarterly thereafter, and revisions made to the plan ifwarranted.	

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	The June, July and August 2014 mood and behavior log was reviewed at the time. The log included the following behaviors being monitored: yelling out, hallucinations (hears voices in her room), agitation, refuses care/tx (treatment), yelling at/hitting others; confusion." Of the behaviors being monitored the following occurrences were documented: 1 occurrence each of yelling at/hitting others on 6/23/14, 7/14 and 7/16, for a total of 3 documented occurrences in 2 months. Documentation was lacking of any of the other behaviors having had occurred which were being monitored. The July 2014 MAR (medication administration record) indicated the following: "Risperdal 0.25 mg...give 1/2 tablet (0.125 mg)...at bedtime DX (diagnosis) psychosis." This medication had an order date of 4/16/14. The August 2014 MAR indicated the following: "Risperdal 0.5 mg...give 1 tablet...at bedtime..." This medication had an order date of 7/14/14. The June and July 2014 nurses notes (NN) were reviewed at the time and documentation was lacking of resident behaviors. On 7/14/14 at 9:35 P.M., the NN indicated the following: "N.O. (new			

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	order)...increase Risperdal to 0.5 mg...r/t (related to)...dementia." On 8/4/14 at 10:50 A.M., the SSD (Social Service Director) was interviewed. She indicated Resident #13 had been at the facility for about a year. She indicated they were monitoring the resident's behavior of "yelling out" as the resident had delusions and hallucinations. The SSD indicated "you can really see she (the resident) is tormented with the delusions and hallucinations." On 7/14/14 the NP "Psychiatric Initial Consult" note included, but was not limited to, the following: "Per staff and Dr. (name of physician), pt (patient) continues to have hallucinations. She continues to yell out. Sometimes pt really seems tormented by her hallucinations. The Assessment/Treatment Plan and Recommendations: "...Increase Risperdone to 0.5 mg from 0.25 mg po q hs. Re-evaluate in a month. Monitor for frequency and effect of delusions, anxiety, yelling out..." On 7/18/14 (name of physician) performed an Initial Psychological Evaluation. This included, but was not limited to, the following: "...referred for evaluation and treatment of problematic			

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	behaviors that are associated with dementia. Per staff, experiences hallucinations or delusions. She was observed having conversations with someone who is not present in the room or in the hallway, kicking or screaming at a person who is not there. Also she tends to get easily "agitated" and yells out frequently, in addition to "hoarding cups...current psychotropic meds (medications):...Risperdal 0.25 mg q hs." This documentation of the current dose of Risperdal was contradictory to the July MAR, which indicated the resident was ordered (on 4/16/14) to receive "Risperdal 0.25 mg...give 1/2 tablet (0.125 mg)...at bedtime." On 8/4/14 at 11:30 A.M. the SSD was interviewed. She indicated the facility had monthly behavior meetings and the following departments attend: pharmacy, SSD, ADM, DON, and the NP and the psych Dr. with the new service. She indicated in the monthly meetings, they review all the resident's who are on psychoactive medications monthly. She indicated they review each resident's information since the prior meeting. She indicated they talk about changes that have been seen and the psychiatric physician also adds in their observations and info. The SSD indicated they also review the behavior logs during this			

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	meeting. She indicated this resident didn't have any recommendations in May, June or July of 2014. On 8/4/14 at 1:25 P.M., CNA (certified nursing assistant) #20 was interviewed. She indicated she was caring for the resident today. She indicated if the resident did have a behavior, she would report it immediately to the nurse. On 8/4/14 at 1:35 P.M. LPN #20 was interviewed. She indicated she was taking care of the resident today and had only been the resident's nurse two other days. She indicated she "wasn't real sure" of the resident's behaviors but that last Thursday or Friday, she (LPN #20) was at the nurses station and heard the resident yell from her room. She indicated the other staff indicated this behavior was "normal" for the resident. Documentation of yelling was lacking on the Mood and Behavior Monthly flow record for this behavior that LPN #20 indicated occurred either the last part of July or the first part of August 2014. On 8/4/14 at 1:43 P.M. the ADM (Administrator) was interviewed. She indicated when a CNA observes a behavior, they (the CNA) fill out a behavior memo and they give it to the SSD, and she (the SSD) logs it in the			

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	behavior log. On 8/4/14 at 1:50 P.M., the SSD (Social Service Director) provided a copy of the "Mood and Behavior Monthly Monitoring Summary" dated 7/28/14. This form indicated the resident was on Risperdal 0.5 mg and "Res (resident) continues to yell out at res as they pass by her doorway. Some outbursts in room also continue. At times outbursts appear disturbing to resident." On 8/4/14 at 3:12 P.M., the Social Service Consultant (SSC) provided a copy of the facility "Mood and Behavior Program" policy and procedure, dated 11/2013. This policy included, but was not limited to, the following: "Documentation of Mood/Behavior: copies of the Mood and Behavior Communication memo will be placed at each nurses station in a location that is accessible to all staff...in an effort to ensure all staff have easy access for completion at the time a resident behavior is witnessed...the Mood and Behavior Communication Memo will be completed by any staff member upon witnessing a resident mood/behavior...The SSD and/or designee will collect the Mood and Behavior Communication Memos during the scheduled days of work and review			

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	all occurrences with the interdisciplinary team (IDT) during the morning meeting...Tracking/Identification of Patterns/Trends...members of the IDT will meet monthly, or as needed, to review the Mood and Behavior Monthly Flow Records. The IDT will utilize the Mood and Behavior Monthly Monitoring Summary during these meetings, in an effort to identify: trends/patterns...efficacy in attempted interventions/efficacy of current psychoactive medication..." On 8/5/14 at 8:30 A.M., the SSD was interviewed. She indicated the dose of Risperdal since 4/16/14 had been 0.25 mg, 1/2 tablet (0.125 mg) until the physician increased the dose on 7/14/14 to 0.5 mg (four times the initial dose), in response to reported behaviors from staff. This was contradictory to the 7/14/14 NP "Psychiatric Initial Consult" which documented the following recommendation: "...increase Risperdone to 0.5 mg from 0.25 mg po q hs..." She indicated she had notified the physician of the documentation discrepancy of the doses of Risperdal and the physician decreased the dose of Risperdal to 0.25 mg on 8/5/14. On 8/5/14 at 10 A.M. the Administrator			

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	(ADM) provided a copy of the physician order, dated 8/5/14: "D/C (discontinue) Risperdal 0.5 mg...q (every) hs (bedtime)...Risperdal 0.25 mg 1...q hs..." 2. On 8/1/14 at 10 A.M. the clinical record of Resident #11 was reviewed. Diagnoses included but were not limited to, the following: depression, chronic pain and mini strokes. The most recent MDS, dated 7/9/14 included, but was not limited to, the following: independent cognition and mood of feeling down, depressed, hopeless, having trouble falling or staying asleep and/or sleeping too much. On 8/1/14 at 11 A.M. the nurse notes (NN) were reviewed from May 2014 to August 2014. On 5/13/14 at 9 P.M.: "Res feeling down this evening thinking about her deceased son. Writer gave alittle [sic] one on one and let resident express herself. That seemed to help a lot." This was the only documentation which indicated the resident was "feeling down." The most recent Social Service note dated 6/8/14 included but was not limited to, the following: "has not exhibited any adverse effects of Prozac (antidepressant) per nursing and behaviors and care plans reviewed and updated. Continue to			

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	monitor through next review." A plan of care, dated 6/12/14 addressed the following problem: "Resident Exhibits depressive symptoms: "fidgety and restless...feeling down...becomes tearful at times..." Interventions included, but were not limited to, the following: "observe for increased s/s (signs/symptoms) of depression: crying, staying in room..." A "Nursing Facility Psychiatric Initial Consult" was dated 7/14/14. This form included, but was not limited to, the following: "Per staff, patient is sad and grieving over her son who was killed in a motor vehicle accident. They feel she has not processed her grief. She frequently complains of pain in many places...Psych: depression...Assessment/Treatment plan and recommendations: Add Cymbalta (antidepressant) 30 mg; increase to 60 mg daily after 1 week. Monitor for frequency of crying and statements about missing her son...." A "Mood and Behavior Monthly Monitoring Summary" dated 7/28/14 was provided by the SSD on 8/4/14 at 4:10 P.M. This form included but was not limited to, the following: Diagnosis of depression, review of mood and behavior			

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	flow record forms - mood/behavior and # (number) of episodes: depression-tearful was 1 episode. Medication of Cymbalta 30 mg x 1 week then increase to 60 mg...Res (resident) mourns loss of her son after all these years, tries to play down her grief." At the time, the SSD indicated the resident had been on other antidepressants in the past but the NP (Nurse Practitioner) felt like Cymbalta would be good for the resident due to her depression and her increase in pain. On 8/4/14 at 1 P.M., the Mood and Behavior logs were reviewed from May - August 2014. These forms indicated the resident was being monitored for "Depression: tearful" and "anxiety." Of the 4 months of behavior logs reviewed, there was one episode of depression/tearfulness documented on 7/11/14. On 8/4/14 at 2:50 P.M. the ADM was interviewed. She indicated the resident was admitted to the facility 12/27/12. She indicated the resident's son was killed 10 -12 years ago. The ADM indicated the resident has a problem when it's her son's birthday and/or the anniversary of his death. The ADM indicated she thinks the anniversary of the resident's son's death and/or birthday had been recently but she isn't sure,			

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	possibly in the last few months. The ADM indicated over the last few months the resident's depression had possibly increased as it was "situational" depression. The ADM indicated most days the resident was "chipper and talkative." The ADM indicated the resident's situational depression over the last few months was exhibited in her being more tearful. The ADM indicated the resident's depression was shown by "mostly tearfulness and alittle [sic] agitation." The ADM indicated at the time, she was unable to find a plan of care which indicated the date of the resident's son's death and/or birthday. The ADM indicated she was unable to find additional documentation of the resident's mood and/or depression were being tracked and/or monitored. 3.1-48(a)(3)			

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F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 2 medication errors out of 27 opportunities for error, resulting in a 7.4% error rate. This affected 2 of 10 residents observed for medication pass (Residents #27 and #7), and 2 of 5 nurses observed to pass medications. (Nurse #5 and #7) Findings include: 1. During the medication pass observation, Nurse #5 was observed to administer Resident #27's insulin (Novolog 5 units subcutaneously) on 8-1-2014 at 11:09 a.m. Resident #27 indicated he would have his noon meal in his room. Resident #27 was not provided a meal or snack after the Novolog	F000332	1. Upon assessment there were no adverse reactionsexperienced by residents #27 and #7. Nurses #5, 7 and 13 were re-educated on providinga meal or snack within the recommended amount of time after administering fastacting insulin. 2. The records of all residents receiving fastacting insulin were reviewed with no revisions necessary. Licensed nursingstaff were re-educated concerning recommended time frames for fast actinginsulin to be given prior to a meal or snack. The medication administration record of each resident with ordered fast acting insulin will be reviewed and revised to include prompting the nurse responsible for administration ensure the meal is served within 10-15 minutes of administration and sign the MAR to denote the same. if the meal is not served, a snack must be served and documented and the resident monitored for signs/symptoms of	09/05/2014

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	injection . A review of the Meal Time Schedule provided by the Administrator on 7-30-2014 at 10:00 a.m., indicated the lunch meal hall trays were scheduled at 11:30 a.m. An observation on 8-1-2014 at 12:04 p.m., indicated the lunch meal hall cart had just arrived on the hall where Resident #27 resided. A review of the signed Physician's recapitulation (recap) for July 2014 indicated Resident #27's diagnoses included but were not limited to, congestive heart failure, hypothyroidism, diabetes, chronic cellulitis of the left lower extremity, depression and anxiety. A review of the Physician's recap for July 2014 indicated an order for Novolog 5 units sub q (subcutaneously) before meals for diabetes. 2. During the medication pass observation, Nurse #7 was observed to administer Resident #7's insulin (Novolog 6 units subcutaneously) on 8-4-2014 at 4:27 p.m. in her room. Resident #7 indicated she would have her evening meal in her room. Resident #7 was not provided a meal or snack after		hypoglycemia until the meal is served. should a resident be served a snack, the resident will still yet be encouraged to consume his/her meal. the assigned nurse remains responsible to monitor residents with diabetes during each tour of duty for potential hypoglycemia and to intervene should a resident appear symptomatic at any time. 3. In an effort to ensure ongoing compliance, the medication administration record of each resident with ordered fast acting insulin will be reviewed and revised to include prompting the nurse responsible for administration ensure the meal is served within 10-15 minutes of administration and sign the MAR to denote the same. if the meal is not served, a snack must be served and documented and the resident monitored for signs/symptoms of hypoglycemia until the meal is served. should a resident be served a snack, the resident will still yet be encouraged to consume his/her meal. the assigned nurse remains responsible to monitor residents with diabetes during each tour of duty for potential hypoglycemia and to intervene should a resident appear symptomatic at any time. The DON and/or designee will observe medication pass specific to residents'receiving fast acting insulin, 5x per week x 1 month, then weekly x 1 month	

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	the Novolog injection . A review of the latest signed Physician's recapitulation (recap) for June 2014 indicated Resident #7's diagnoses included but were not limited to, gastroesophageal reflux disease, peripheral vascular disease and diabetes. A review of the June 2014 recap for Resident #7 indicated the order for Novolog was to inject sub q (subcutaneously) per sliding scale. The sliding scale was based on a glucose check before meals and at bedtime with a blood sugar of 181 - 250 = 4 units of Novolog would be given; a blood sugar of 251 - 300 = 6 units of Novolog would be given and a blood sugar of 301 - 350 = 8 units of Novolog given. A review of the Blood Glucose Monitoring Sliding Scale Insulin Record for Resident #7 indicated on 8-4-2014 at 4:35 p.m. the blood sugar was 290 and the units of Novolog given were 6. An observation of the dining schedule located in the 100 hall on 8-4-2014 at 5:00 p.m., indicated the hall trays were scheduled at 5:30 p.m. An interview with Nurse #8 on 8-5-2014 at 11:21 a.m., indicated she had a chart		thenmonthly thereafter, to assure insulin is given within the recommended timeframe and resident receives a meal or a snack timely. Should concerns be noted,corrective action shall be taken. 4. As a means of quality assurance, the DON and /ordesigneewill report the findings of these observations and any correctiveactions taken to the QA committee monthly x 3 months and quarterly thereafter,and revisions made to the plan if warranted.	

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	with her name badge that indicated the Novolog insulin onset was "0.25 hours". Nurse #5 indicated she was not sure all nurses had this information but they had 2 drug books (2006 Nursing Drug Reference and the 2009 Lexi-comp's Drug Reference Handbook) that were available to the nursing staff. An interview with Nurse #13 on 8-5-2014 at 11:35 a.m., indicated residents who were given the Novolog insulin, should be provided a meal within 15 to 30 minutes after the injection was given. An interview with the Corporate Nurse on 8-5-2014 at 1:40 p.m., indicated there was not a policy for insulin injections and the facility would follow the information in the 2 nursing drug books (2006 Nursing Drug Reference and the 2009 Lexi-comp's Drug Reference Handbook). On 8-5-2014 at 1:43 p.m., a review of the 2006 Nursing Drug Reference indicated the "onset of Novolog was 0.25 hours (15 minutes)...." On 8-5-2014 at 1:45 p.m., a review of the 2009 Lexi-comp's Drug Reference Handbook indicated "...with Novolog, you must start eating within 5-10 minutes after injection...."			

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	3.1-25(b)(9)			
F000334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.			

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	The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on interview and record review, the facility failed to ensure Influenza and Pneumonia consent forms were dated as to when consent was given and/or were given additional opportunity for administration of a vaccine after refusal for 2 of 6 residents reviewed for	F000334	1. Resident # 11 and Resident # 5 consents weresigned and dated immediately. 2. All other resident records reviewed and Flu andPneumonia vaccine consents were obtained containing resident or legalrepresentative signature and	09/05/2014

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	Influenza and Pneumonia vaccines. Resident #11, Resident #5 Findings include: On 8/6/14 at 11 A.M., the clinical record of Resident #11 was reviewed. An "Influenza Vaccine Consent" was dated 12/27/12 and indicated the resident "refused" the influenza (flu) vaccine. A notation on the form indicated the resident had received the vaccine already at another facility. The current immunization record, indicated the resident received the annual flu vaccine on 10/17/13. On 8/6/14 at 12:35 P.M., the RN Consultant and Administrator (ADM) were interviewed. They indicated the facility will send out consent forms for the flu and pneumonia vaccines along with education information to the families/responsible parties. She indicated if these are not returned, they call the families/responsible to obtain verbal consent. She indicated the staff also find out the date the resident's last had the pneumonia vaccine as well. At the time, the ADM provided a copy of the "consent" Resident #11 had signed to receive the flu vaccine. This form began		date signed. 3. In an effort to ensure ongoing compliance, theAdministrator and/or designee will assure all residents Flu/Pneumonia Vaccineconsents are signed by resident or legal representative and dated.Administrator and/or designee will audit consent documentation to assuresignature and date signed is complete upon admission and as needed thereafter. 4. As a means of quality assurance, theAdministrator and/or designee will report the findings of these audits and anycorrective actions taken to the QA committee monthly for 3 months thenquarterly thereafter, and revisions made to the plan if warranted	

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	with "Dear Resident/Responsible party for "Resident #11's name." At the bottom of the form was the following: "The current Consent on file indicates: consent has been given and the influenza vaccine is to be administered; consent has been declined, thus the Influenza vaccine is NOT to be administered..." For Resident #11, the first line had been checked for the vaccine to be administered. Documentation was lacking of a date and/or signature of the resident and/or responsible party. At the time, the ADM indicated they had gotten a signed consent for this resident on admission but just got another consent signed. At the time, she provided a copy of the signed consent. The consent lacked a date the form was signed. On 8/6/14 at 1 P.M., the clinical record of Resident # 11 was reviewed. The most recent MDS (minimum data set) assessment, dated 7/9/14, indicated the resident was of independent cognition. At the time, the clinical record of Resident #5 was also reviewed. The most recent MDS, dated 6/20/14, indicated the resident was of independent cognition. At the time, the "Immunization...Record"			

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	for Resident #5 was reviewed. The form indicated the resident had refused a pneumonia vaccine but documentation was lacking as to the date the resident refused the vaccine and/or the resident having been offered the vaccine again. Documentation was also lacking whether or not the resident had a pneumonia vaccine in the past and if so the date. This form indicated the resident was admitted to the facility in December 2012. On 8/6/14 at 1:20 P.M., the RN Consultant was interviewed. She indicated documentation was lacking of the date Resident #5 refused the Pneumonia vaccine and/or Resident #5 having been given the opportunity to take the Pneumonia vaccine at a later date. On 8/6/14 at 1:30 P.M., the current "Immunization Program" policy was provided by the DON. This policy was undated and included, but was not limited to, the following: "Pneumococcal immunizations will be given one time if it is determined the resident has not received one within the past 5 years, and were less than 65 years old at the time of vaccination. Repeat immunizations will be ordered by the...physician and administered as directed..." The DON also provided a current, undated copy of			

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	the policy and procedure for "Annual Influenza immunization procedure." This policy included, but was not limited to, the following: "Consent must be given prior to administration of the vaccine either by the resident or responsible party/sponsor." 3.1-13(a)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure staff washed their hands for the recommended amount of time and failed to ensure staff washed their hands after touching soiled surfaces during meal service in the dining room and with hall tray service potentially affecting 32 of 33 residents who ate meals prepared by the facility. Findings include:	F000371	1. Restorative #3, C.N.A.'s # 4, 1, 6, 2, 9, RN #5,and LPN # were re-educated on proper distribution and meal service undersanitary conditions. 2. As all residents could be affected, all staff wasre-educated on proper distribution and meal service under sanitary conditionsincluding but not limited to: Proper hand washing technique with returndemonstration; when to wash hands- including but not limited to, after moving astool, coughing, rubbing residents' back, moving a resident's chair, removing asoiled clothing	09/05/2014

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	1. During an observation of the lunch meal in the dining room on 7/30/14, the following was observed: - At 11:48 a.m., Restorative #3 was observed to lather his hands for only 8 seconds before rinsing. He was observed to serve a meal tray to a resident. - At 11:50 a.m., Restorative #3 was observed to lather his hands for only 6 seconds before rinsing. He was observed to continue passing meal trays to residents. - At 11:52 a.m., Certified Nursing Assistant (CNA) #4) was observed to lather her hands for 15 seconds before rinsing. She was observed to pass meal trays to residents. - At 11:57 a.m., CNA #1 was observed to move a stool on wheels over to a dining table where 3 residents were seated by placing her hands on the seat of the stool. - At 12:00 p.m., CNA #1 was observed to cough into her arm while seated on the stool at the table with the 3 residents. She was observed to rub the backs of 2 of the residents seated at the table and then move a 2 handled cup closer to a resident for him to reach. She was not observed to wash her hands after moving the stool		protector, picking up crumbs of food, after using keys to opendoor, placing hands on hips, pushing hair behind ear, before passing beverages,meal trays, picking up utensils etc. Staff should not touch the rims of any cupor dish served to residents. 3. In an effort to ensure ongoing compliance withdistributing and serving food under sanitary conditions, the Administrativestaff will monitor meals at varied times 5 days per week x 4 weeks then weeklyx 4 weeks and monthly thereafter, to assure proper distribution and mealservice under sanitary conditions. Should concerns be observed, correctiveaction shall be taken. 4. As a means of quality assurance, the Administratorand/or designee will report the findings of these audits to the QA committee monthlyfor 3 months then quarterly thereafter, and revisions made to the plan ifwarranted.	

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	on wheels, touching the backs of residents, or coughing. - At 12:02 p.m., CNA #1 was observed to remove a clothing protector from a resident seated at another table and assist him to leave the dining room by pushing his wheelchair. She was observed to re-enter the dining room, speak with a resident, and use her key from her uniform pocket to open the door to the kitchen and request additional food for the resident she had just spoken to. CNA #1 was not observed to wash her hands after she returned to the dining room. - At 12:04 p.m., CNA #1 was observed to return to the table with the 3 residents and sit on the stool on wheels. She was observed to rub the back of a resident. - At 12:05 p.m., CNA #1 was observed to sit at a table with another resident. - At 12:07 p.m., CNA #1 was observed to cough into her arm and then pick up a drinking glass and hand the glass to the resident. CNA #1 was not observed to wash her hands after touching the back of a resident or after coughing. - At 12:12 p.m., CNA #1 was observed to cough into her arm. She then used her key from her uniform pocket to open the			

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	door to the kitchen and request additional food for a resident. She was observed to remove a soiled clothing protector from a dining room table, immediately went over to another dining table, and moved a dinner plate closer to a resident for him to reach while eating. CNA #1 was not observed to wash her hands after coughing or touching soiled objects. 2. During an observation of the lunch meal in the dining room on 7/31/14, the following was observed: - At 11:43 a.m., Restorative #3 started beverage service in the dining room. He was observed to stop the service to assist a resident leave the dining room by pushing his wheelchair. - At 11:43 a.m., CNA #1 was observed to pick up crumbs of popcorn from the clothing protector of a resident and then continue the beverage service which had been started by Restorative #3. CNA #1 was not observed to wash her hands prior to passing beverages to residents. - At 11:52 a.m., Restorative #3 returned to the dining room and was observed to lather his hands for only 6 seconds before rinsing. He was observed to pass meals trays to residents.			

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	- At 11:53 a.m., CNA #1 was observed to pass meal trays to residents. She was then observed to pick up a knife and fork for a resident in order to cut his meat. CNA #1 then placed the fork into the hand of the resident. CNA #1 was not observed to wash her hands before passing meal trays or picking up the eating utensils of a resident. - At 11:55 a.m., RN #5 was observed to enter the dining room and lather her hands for 15 seconds before rinsing. She was observed to serve meal trays to residents. - At 11:58 a.m., RN #5 was observed to lather her hands for 14 seconds before rinsing. She was observed to serve meal trays to residents. - At 11:57 a.m., CNA #1 was observed to move a stool on wheels over to a table with a resident by placing her hands on the seat of the stool. She then was observed to move a mug of hot chocolate and a glass of water closer to the resident. CNA #1 was not observed to wash her hands after touching the stool. - At 11:59 a.m., CNA #6 was observed to lather her hands for only 7 seconds before rinsing. She was observed to sit at a table to assist a resident with her meal.			

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	- At 12:01 p.m., CNA #1 was observed to leave the dining room. - At 12:03 p.m., CNA #1 was observed to re-enter the dining room and pour a glass of water and a cup of coffee for a resident. She was not observed to wash her hands when she re-entered the dining room. - At 12:04 p.m., CNA #1 was observed seated with a resident at a dining room table. She was observed to cough into her arm. CNA #1 was not observed to wash her hands, but remained seated at the table with the resident. - At 12:09 p.m., CNA #1 was observed seated with the same resident at a dining room table. She was observed to cough into her arm. CNA #1 was not observed to wash her hands, but remained seated at the table with the resident. 3. During an observation of the lunch meal in the dining room on 8/4/14, the following was observed: - At 11:48 a.m., CNA #2 was observed to lather her hands for only 9 seconds before rinsing. She was then observed to touch the back of her uniform and leave the dining room.			

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	- At 11:50 a.m., CNA #2 was observed to re-enter the dining room and use her key to open the door to the kitchen. She then placed both hands on her hips, moved a stool on wheels over to a table with a resident by placing her hands on the seat of the stool. CNA #2 was observed to place a clean clothing protector on the resident without washing her hands. - At 11:52 a.m., LPN #7 was observed to enter the dining room and place a clean clothing protector on a resident. She was not observed to wash her hands. - At 11:56 a.m., CNA #2 was observed to lather her hands for only 8 seconds before rinsing. - At 11:58 a.m., CNA #2 was observed to move drinking glasses of beverages in front of a resident by touching the rims. - At 12:00 p.m., CNA #2 was observed to move drinking glasses of beverages in front of another resident by touching the rims. - At 12:02 p.m., CNA #2 was observed to touch the handle of a spoon and give the spoon to a resident. - At 12:03 p.m., CNA #2 was observed to			

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	lather her hands for only 8 seconds before rinsing. She was observed to move a stool on wheels to a table with a resident to assist her to eat by placing her hands on the seat of the stool. CNA #2 was observed to pick up a small bowl of ground meat by touching the rim of the bowl. She was not observed to wash her hands after touching the stool. The Administrator, the Director of Nursing, and the Consultant Nurse RN were interviewed on 8/5/14 at 4:22 p.m. During the interview they indicated staff were to lather their hands for 20 seconds. They also indicated staff were to wash their hands when entering the dining room, after touching a resident, after touching their face or uniform, and after touching anything soiled. 4. During an observation of the lunch meal hall tray pass for 19 residents on 7/30/14, the following was observed: -At 11:35 a.m., the enclosed tray cart arrived. CNA #2 was not observed to perform hand hygiene or handwashing prior to serving 8 of 19 meal trays to residents. -At 11:43 a.m., CNA #2 served a meal tray to room 211. CNA #2 pushed her hair behind her ear with her hand and no hand hygiene was done.			

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	-At 11:46 a.m., CNA #2 served a meal tray to the resident in room 207 with no hand hygiene or handwashing observed. -At 11:49 a.m., CNA #2 served meal trays to residents in rooms 303 and 305. No hand hygiene or handwashing was observed to be done. -At 11:52 a.m., CNA #2 served a meal tray to the resident in room 400. CNA #2 assisted the resident up to her wheelchair, locked the brakes on the wheelchair and proceeded to open a yogurt container for the resident. No hand hygiene or handwashing was observed after touching the resident and the resident's wheelchair. -At 11:56 a.m., CNA #2 served a meal tray to the resident in room 404. No hand hygiene or handwashing was observed before or after serving the resident their meal tray. -At 11:58 a.m., CNA #2 served a meal tray to a resident in room 408. CNA #2 used a fork to remove items the resident did not like from the salad, obtained a snack from the resident's personal snack supply and opened the snack, put salad dressing on salad and mixed it up with the resident's fork and was observed to wash her hands at the resident's sink for 5			

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	seconds. -At 12:02 p.m., CNA #2 served a meal tray to a resident in room 409 with no hand hygiene or handwashing observed before or after serving the tray. An interview with CNA #9 on 8-5-2014 at 2:32 p.m., indicated hand hygiene was to be done after delivering every hall tray and handwashing was to be done after every third hall tray delivered. A current undated facility policy "Handwashing Procedure", provided by the Administrator on 8/5/14 at 4:30 p.m., indicated "...To provide protection for resident...and assist in the prevention of and the transmission of disease and infection...Wet hands and wrists. Rub vigorously for at least 15 seconds...Specific times hands must be washed: Before and after direct resident contact...Before and after handling of food...." 3.1-21(i)(1) 3.1-21(i)(2)			
F000431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who			

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	establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure 4 of 4 medication carts and 2 of 2 treatment carts were clean. This practice had the potential to affect the 33 residents who resided in the building. Findings include:	F000431	1. All medication carts and Treatment carts werecleaned immediately. 2. All medication carts and treatment carts werecleaned immediately. Nursing staff re-educated on cleaning medication carts andtreatment carts properly, and a schedule was implemented to assure all	09/05/2014

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	1. On 8-6-2014 from 8:50 a.m. to 9:04 a.m., the 2 medication carts for North and West halls and the 1 treatment cart for North and West hall were reviewed with Nurse #7 and the following observations were made: - The 2nd drawer of the West medication cart had dust and debris in the back of the drawer. -The side containers on the North and West medication carts that hold the small plastic medication cups, spoons and the drinking cups had dust and debris in the bottom. -The side of the North and West medication cart by the trash container had white and brown splatters on the side of the carts. -The North Medication cart had white debris in the back of the second drawer and a sticky substance in the third drawer. -Both North and West medication and treatment carts were not clean on the tops and outside. An interview with Nurse #7 on 8-5-2014 during the medication/treatment cart		cartsare cleaned on a regular basis, and as needed. 3. As a means to ensure ongoing compliance, the DONand/or designee will observe the cleanliness of medication carts at variedtimes on varied shifts 5x/week x 4 weeks, then weekly thereafter, shouldconcerns be observed, corrective actions will be taken. 4. The DON and/or designee will report the findingsof these audits and any corrective actions taken to the QA committee monthlyfor 3 months then quarterly thereafter, and revisions made to the plan ifwarranted.	

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	review from 8:50 a.m. to 9:04 a.m., indicated the Micro-kill bleach wipes were used for cart cleaning. Nurse #7 indicated she was not aware of the cleaning schedule for the medication and treatment carts. 2. On 8-6-2014 from 9:05 a.m. to 9:32 a.m., the 2 medication carts for South and East halls and the 1 treatment cart for South and East halls were reviewed with Nurse #8 and the following observations were made: -The South hall medication cart had white debris and paper pieces in the back of the 2nd, 3rd and 4th drawers. -The side containers on the South and East medication carts that hold the small plastic medication cups, spoons and the drinking cups had dust and debris in the bottom. -The East medication cart had white particles, paper pieces and assorted pills--whole, half and pieces located in the bottom of the second and third drawers. At least 12 tablets were obtained by Nurse #8 from the bottom of the second and third drawers. -The side of the East medication cart by the trash container had white and brown			

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	splatters on the side of the cart. -Both South and East medication and treatment carts were not clean on the tops and outside. -The treatment cart for the South and West hall had a sticky residue in the second drawer. An interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 8-6-2014 at 9:30 a.m., indicated they were not aware of the loose tablets and debris in the bottom of the drawers, the debris in the side containers and the brown and white splatters on the medication carts side by the trash container. The DON and ADON were not aware of documentation which indicated when the carts were cleaned. An interview with Nurse #8 on 8-6-2014 at 9:32 a.m., indicated the nurse was not aware when the medication and treatment carts were last cleaned. Nurse #8 indicated there was a sign off sheet for the cleaning of the carts, but the nurse did not know where it was located now. An interview with the ADON on 8-6-2014 at 9:43 a.m., indicated she worked this past Saturday night until 2			

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	a.m. The ADON indicated she did not clean the medication or treatment carts and the nurse that came in at 2:00 a.m. was Nurse #7. (In a previous interview on 8-6-2014 during the medication/treatment cart review from 8:50 a.m. to 9:04 a.m. with Nurse #7, the nurse indicated she was not aware of the cleaning schedule for the medication and treatment carts.) A review of the "Basic Night Shift Duties" sheet provided by the DON on 8-6-2014 at 9:40 a.m. which was in the night shift cleaning book located at the nurse's station indicated "...clean Med (Medication) & TX (Treatment) Carts q (every) Sat. (Saturday)...." A review of the "Third Shift daily duties" sheet provided by the DON on 8-6-2014 at 9:40 a.m. which was in the night shift cleaning book located at the nurse's station indicated "...Nurse = Third Shift daily duties...Clean Medication cart as needed...." was marked as a daily duty. An interview with the DON on 8-6-2014 at 9:40 a.m., indicated there was not a facility policy regarding the cleaning of the medication and treatment carts, or a check off list which would have indicated when the medication and treatment carts were cleaned.			

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	An undated policy "Equipment and Supplies" provided by the DON on 8-6-204 at 12:54 p.m., indicated "...the charge nurse on duty has the responsibility to assure equipment and supplies relating to drug storage and use are clean...." 3.1-25(m) 3.1-25(n)			
F000441 SS=E	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. (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			

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	resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure clean linens and clothing protectors were transported in a manner to prevent infection by 2 of 2 staff observed during 4 of 4 observations. This deficient practice had the potential to affect the 33 residents who resided in the building. (CNA #6 and CNA #2) Findings include: 1. During an observation on 7-30-2014 at 10:53 a.m., CNA #6 was observed in the East hall carrying a stack of clean	F000441	1. C.N.A.'s #6 and 2 were re-educated on properhandling of linens. 2. All staff re-educated on the proper handling oflinens, including but not limited to not holding linens against uniforms. 3. As a means to ensure ongoing compliance withtransporting linen in a manner to prevent infection, the DON and/or designeewill monitor staff handling of linens at varied times on varied shifts 5x/weekx 1 month then weekly thereafter to assure using proper procedure. Shouldconcerns be observed, corrective actions will be taken. The laundry staff willprovide a	09/05/2014

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	linens up against her uniform top. The clean linens were carried into a resident's room. 2. During an observation on 7-30-2014 at 11:34 a.m., CNA #6 was observed in the area of the nurse's station carrying a stack of clean towels up against her uniform top. The clean towels were carried to a resident's room in the East hall. 3. During an observation on 7-31-2014 at 9:31 a.m., CNA #2 was observed carrying a stack of clean towels up against her uniform top. The clean towels were carried to the residents' shower room. An interview with the Housekeeping Manager on 8-5-2014 at 1:52 p.m., indicated staff should remove the clean linen from the clean linen room and either place on the clean linen cart or place in a bag to carry to a resident's room or to the shower room. The Manager indicated the clean laundry should not be held up against the uniform. An interview with CNA #10, CNA #9 and CNA #6 on 8-5-2014 at 1:58 p.m., indicated the laundry cart should be used to transport clean linen from the clean		cart with clean clothing protectors available at meal times. 4. As a means of quality assurance, the DON and/ordesignee will report the findings of the observations and any correctiveactions taken to the QA committee monthly x 3 months, then quarterlythereafter, and revisions made to the plan, if warranted.	

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	linen closet to a resident's room and the clean linen cart should be covered. 4. During an observation on 8/4/14 at 11:47 a.m., CNA #2 was observed to enter the dining room carrying a stack of 8 clean clothing protectors up against her uniform top. The clothing protectors were placed on top of a piano ready to be used for residents. An undated Laundry policy from the Housekeeping Manual provided by the Housekeeping Manager on 8-5-2014 at 2:15 p.m., indicated "the rack of...clothing...delivered daily by nursing or laundry personnel...." The Manager indicated there was no other policy regarding the transport of clean linens. 3.1-19(g)(2)			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure 6 resident bathrooms (room 407 and 409 shared bathroom, room 402 and 404 shared bathroom, and rooms 408, 411, 412 and 414) had clean and intact caulking and unstained flooring in	F000465	1. Residents #17, 1, 21, 31, 30, 10, 27, 2, and 26were not affected. The cracked and stained caulking and tiles in rooms 407/409,402/404, 408, 411, 412, and 414 were removed and replaced. 2. All resident rooms were audited to check for anyfurther	09/05/2014

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	bathrooms and sink areas. This affected 9 of 33 residents who resided in the facility. (Residents #17, #1, #21, #31, #30, #10, #27, #2 and #26) Findings include: 1. During an observation on 7-31-2014 at 8:49 a.m., the shared bathroom for rooms 407 and 409 had a two inch area surrounding the base of the toilet which was a rusty brown stain. This bathroom was shared by Residents #17, #21 and #1) 2. During an observation on 7-31-2014 at 1:34 p.m., the shared bathroom for rooms 402 and 404 had caulk around the base of the toilet that did not cover the area from the toilet to the floor. The caulk around the entire circumference of the toilet was stained a rusty color. This bathroom was shared by Residents #31 and #30. The caulking around the sink in room 404 was jagged and dirty. 3. During an observation on 7-30-2014 at 3:35 p.m., the bathroom toilet and sink caulking for room 408 was stained a rusty brown color, the bathroom was used by Resident #10. 4. During an observation on 7-30-2014 at 4:01 p.m., the caulking around the base		areas of concern with cracked, stained caulking and tiles with repairsmade as warranted. 3. As a means to ensure ongoing compliance withprovision of a safe, sanitary environment, the Maintenance Supervisor willmonitor resident rooms on a daily basis on scheduled days of work to assurerooms are free from cracked and stained caulking and tile. Any areas of concernnoted during monitoring will be corrected immediately. 4. The Maintenance Supervisor will report findingsof audits and any corrective actions taken to the QA committee monthly x 3months then quarterly thereafter, and revisions made to the plan if warranted.	

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	of the toilet in room 411 was stained a rusty brown color, the bathroom was used by Resident #27. 5. During an observation on 7-31-2014 at 10:00 a.m., the area around the base of the toilet in room 412 was stained a rusty brown color, the bathroom was used by Resident #2. 6. During an observation on 7-30-2014 at 2:21 p.m., the area around the toilet had rusty brown stains in the caulk and cracks of the floor in room 414. There was missing caulk and brownish stains in the caulk around the sink, the bathroom was used by Resident #26. During a walk through inspection with the Administrator on 8-5-2014 at 1:40 p.m., the following was observed: - Rooms 407 and 409 shared a toilet area--the floor had brownish rusty stains around the toilet and a urine odor. - Rooms 402 and 404 had caulk around the toilet which was brownish and rust stained and room 404's sink had cracked caulking with jagged edges surrounding sink. - Room 408 caulking around the toilet was stained a brownish, rusty color and the caulk area around the sink was stained brown.			

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	- Room 411 caulking around the toilet was stained a brownish, rust color. - Room 412 caulking around the toilet rusty stained - Room 414 flooring around the toilet stained a brown color and the caulk around the sink was stained brown and some caulk was missing. An interview with the Administrator on 8-5-2014 at 1:50 p.m., indicated the following: - The facility was working on remodeling and replacing sinks and toilets. - The Maintenance Supervisor was responsible to complete any remodeling updates as well as the maintenance of the building. - It had been difficult for the Maintenance Supervisor to complete the remodeling and updating along with the regular maintenance of the building. - Room 211 recently had an update, but when the Administrator showed the room, the caulking around the toilet was stained a rusty color. - Replacements of facility fixtures or flooring required pre-approval from the facility's corporate office. An interview with the Housekeeping Manager on 8-5-2014 at 1:40 p.m., indicated the housekeeping staff were to clean residents' bathrooms daily and			

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	scrub around the base of the toilet. The Housekeeping Manager indicated the stains on the caulking and floor around the toilets and sinks did not come out after scrubbing. A review of the Resident Council Minutes from 4-17-2014 on 8-5-2014 at 3:50 p.m., indicated housekeeping concerns from residents "...staff were not cleaning properly, dirty mop water, dusty walls and pictures and smeary floor...." The Concern detail report for housekeeping indicated "picture frames dusty-not cleaning handrails; dirty mop water, not moving furniture to sweep and mop, floors are smuggie [sic]...." The housekeeping department response indicated "the Administrator does a walk through every month; room checks done every other day and room scores are great" with the form signed by the Housekeeping Manager on 4-21-2014. An undated policy, "Bathroom Cleaning" provided by the Housekeeping Manager on 8-5-2014 at 2:15 p.m., indicated "...pay close attention to...mopping around the commode...sanitize commode...base...damp mop...ensure to get behind the commode...." 3.1-19(f)			

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F000520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility failed to	F000520	1. Corrective actions as described in the plan ofcorrection were taken for all residents relative to	09/05/2014

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	implement an action plan for the identified concerns regarding the dignity of the residents during meal service, maintaining resident's nutrition status, monitoring resident's weights, reporting resident's weight loss to the physician, monitoring the use of antipsychotic and antidepressant medications, monitoring, documenting and , providing a meal or snack within the recommended amount of time after administering a fast acting insulin, the documentation of the resident's consent for the influenza vaccine annually, staff handwashing during meal service, maintaining clean medication and treatment carts, staff carrying clean linens against their uniforms, and maintaining caulking around sinks and toilets and stained flooring in resident's bathrooms which had the potential to affect 33 of 33 residents who resided at the facility. Findings include: The QA committee consisted of the Administrator, the DON (Director of Nursing), the ADON (Assistant Director of Nursing, the Medical Director and the Managers of each of the Facility's Departments. The committee met monthly and failed to identify and to implement an action plan to correct and		concerns of: dignity of theresidents during meal service, maintaining residents' nutritional status,monitoring residents' weights, reporting residents' weights to the physician,monitoring the use of anti-psychotic and antidepressant medications, monitoring,documenting, providing a meal or snack within the recommended amount of timeafter administering a fast acting insulin, the documentation of the resident'sconsent for the influenza vaccine annually, staff hand washing during mealservice, maintaining clean medication and treatment carts, staff carrying cleanlinens against their uniforms, and maintaining caulking around sinks andtoilets and stained flooring in residents' bathrooms. 2. All residents could be affected,thus thefollowing corrective actions have been taken. Administrative staff has reviewed the current Quality AssuranceCommittee procedures, adding to the monthly meeting, audits to include but notlimited to dignity of the residents during meal service, maintaining residents'nutrition status, monitoring residents' weights, reporting residents' weightsto the physician, monitoring the use of anti-psychotic and antidepressantmedications, monitoring, documenting, providing a meal or snack within	

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	monitor the dignity of the residents during meal service, maintaining resident's nutrition status, monitoring resident's weights, reporting resident's weight loss to the physician, monitoring the use of antipsychotic and antidepressant medications, monitoring, documenting and , providing a meal or snack within the recommended amount of time after administering a fast acting insulin, the documentation of the resident's consent for the influenza vaccine annually, staff handwashing during meal service, maintaining clean medication and treatment carts, staff carrying clean linens against their uniforms, and maintaining caulking around sinks and toilets and stained flooring in resident's bathrooms. An interview with the Administrator on 8-6-2014 at 12:00 p.m., indicated the QAA Committee met monthly and indicated they were not aware of the dignity concerns. She indicated the staff was in-serviced often on handwashing and residents' behaviors but these issues were not addressed by the QAA Committee. She also indicated any medication errors are review with the nursing staff. The Administrator indicated action plans were not developed for the identified concerns. The Administrator indicated the		therecommended amount of time after administering a fast acting insulin,the medication administration record of each resident with ordered fast acting insulin will be reviewed and revised to include prompting the nurse responsible for administration ensure the meal is served within 10-15 minutes of administration and sign the MAR to denote the same. if the meal is not served, a snack must be served and documented and the resident monitored for signs/symptoms of hypoglycemia until the meal is served. should a resident be served a snack, the resident will still yet be encouraged to consume his/her meal. the assigned nurse remains responsible to monitor residents with diabetes during each tour of duty for potential hypoglycemia and to intervene should a resident appear symptomatic at any time. thedocumentation of the residents consent for the influenza vaccine annually,staff hand washing during meal service, maintaining clean medication andtreatment carts, staff carrying clean linens against their uniforms, andmaintaining caulking around sinks and toilets and stained flooring inresidents' bathrooms. 3. Administrative staff has reviewed the currentQuality Assurance Committee procedures, adding to the monthly meeting, auditsto include	

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	identified/found concerns during the survey were not identified by the Committee, and no action plans were implemented. On 8-6-2014 at 12:42 p.m., the Administrator provided the non-dated facility's policy, titled, Quality Improvement Program-Nursing Department, which indicated, "...To assure that quality care is provided to the residents prior to, at the time of and after the delivery of care....identify areas in need of improvement in resident care....To implement action for resolution of known problem areas at the time of care delivery.... 3.1-52(a)(2)		but not limited to dignity of the residents during meal service,maintaining residents' nutrition status, monitoring residents' weights,reporting residents' weights to the physician, monitoring the use ofanti-psychotic and antidepressant medications, monitoring, documenting,providing a meal or snack within the recommended amount of time afteradministering a fast acting insulin, the medication administration record of each resident with ordered fast acting insulin will be reviewed and revised to include prompting the nurse responsible for administration ensure the meal is served within 10-15 minutes of administration and sign the MAR to denote the same. if the meal is not served, a snack must be served and documented and the resident monitored for signs/symptoms of hypoglycemia until the meal is served. should a resident be served a snack, the resident will still yet be encouraged to consume his/her meal. the assigned nurse remains responsible to monitor residents with diabetes during each tour of duty for potential hypoglycemia and to intervene should a resident appear symptomatic at any time, the documentation of the residents consentfor the influenza vaccine annually, staff hand washing during meal service,maintaining	

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			clean medication and treatment carts, staff carrying clean linensagainst their uniforms, and maintaining caulking around sinks and toilets andstained flooring in residents' bathrooms. 4. As a means of Quality Assurance, theAdministrator and/or designee, the DON and/or designee shall report thefindings of aforementioned audits and immediate corrective actions taken to theQA committee during monthly meetings. Further correctiveactions shall be planned/executed by the committee as warranted with follow upreporting provided/reviewed at the next QA meeting in an effort to continuallyidentify issues with respect to which quality assessment and assuranceactivities are necessary and develop and implement appropriate plans of actionsto correct identified quality deficiencies.	