

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2013
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NAME OF PROVIDER OR SUPPLIER  WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00122536.</p> <p>Complaint IN00122536-Substantiated. Federal/State deficiencies related to the allegations are cited at F311, F353, F318 and F282.</p> <p>Survey dates: March 4, 5, 6, 7, 8, 11, and 12 2013</p> <p>Facility number: 000016 Provider number: 155042 AIM number: 100291500</p> <p>Survey team: Terri Walters RN TL 3/4, 3/6, 3/7, 3/8, 3/11, 3/12/13 Carole McDaniel RN Martha Saull RN Dorothy Watts</p> <p>Census bed type: SNF: 14 SNF/N: 116 Total : 130</p> <p>Census payor type: Medicare: 25 Medicaid: 80 Other: 25 Total: 130</p> <p>Complaint sample: 5</p> <p>These deficiencies reflect state findings cited in</p>	F000000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective April 11, 2013 to the annual licensure survey conducted on March 4, 2013 through March 12, 2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	accordance with 410 IAC 16.2.			

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F000244 SS=D	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to act on resident concerns expressed in 2 of 2 resident council meetings and during 5 of 17 confidential resident interviews.</p> <p>Findings include:</p> <p>1. During confidential interviews with 2 of 2 residents who frequently attended resident council meetings they indicated they did not feel problems were thoroughly analyzed and/or resolved following the meetings. Their comments were : "we don't get answers, don't get to the bottom of it..." and" We do tell our concerns in the meetings but its more social and nothing constructive happens."</p> <p>The Social service director was interviewed on 3/12/13 at 11:00 A.M. She indicated the Activity department supervisor was in charge of Resident Council, although she tried to attend</p>	F000244	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective April 11, 2013 to the annual licensure survey conducted on March 4, 2013 through March 12, 2013<b>F244 It is the practice of Willow Manor to always respond and act on any concerns addressed during resident council. The correction action taken for those residents found to be affected by the deficient practice include:</b> No specific residents were identified. However, the most recent resident council minutes have been reviewed with the necessary actions to resolve any resident concerns. <b>Other residents that have the potential to be affected have been identified by:</b> Potentially any resident could</p>	04/11/2013			

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	<p>herself periodically.</p> <p>The resident council meeting minutes were reviewed on 3/12/13 at 1:00 P.M.</p> <p>On 1/22/13, the council met and complained of cold food and meals not being served on time. Documentation reflected the resident's concern was forwarded to the Dietary department for resolution. The Certified dietary Manager provided a written response " Food logs show food in temp range. Meals are ready for service on time and is our continual goal."</p> <p>On 2/25/13 the council met and again complained of cold food. Documentation reflected again the dietary department was given the concern and responded in writing "Checked food temps and all within range."</p> <p>Documentation was lacking to indicate the residents had been contacted for additional information, other departments had been involved i.e. Nursing department, who was responsible for meal delivery.</p> <p>2. There were 5 of 17 residents confidentially interviewed who indicated they were getting cold food.</p>		<p>be affected. Please refer to systems below to prevent reoccurrence. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The Activities Department will continue to be involved with the resident council meeting as is the previous practice of the facility. The new system will include bringing the resident council minutes to the IDT review that occurs each business day. The IDT team will review any concerns that could be pertinent to their department. Actions will be taken by the appropriate departments to assure that any concern is resolved. The Administrator will have the last review and will assure that there is follow-up with the resident(s) that had any concerns to assure they are satisfied with the resolution. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b>The resident council minutes will have a follow-up form that identifies correction of the concern as well as follow-up with the resident(s) to assure satisfaction with the resolution. The Administrator, or designee, is responsible for reviewing the completed form to assure that all components have been completed appropriately. This form will be reviewed by the Quality Assurance Committee at</p>		

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	<p>On 3/12/13 at 2:15 P.M. the administrator was informed of the problem. She indicated she reviewed the resident council meeting minutes and was aware of the complaint. She indicated one resident had complained to her on a day she was working in the dining room and knew he had not gotten cold food but indicated he may have been thinking of another meal.</p> <p>3.1-3(l)</p>		<p>the regularly scheduled meetings monthly and will be monitored on an ongoing basis. Any recommendations for change that may be made will be acted upon. <b><i>The date the systemic changes will be completed:</i></b> April 11, 2013</p>		

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation and interview, the facility failed to provide appropriate dining table height for 1 of 1 resident in a specialized low wheel chair. Resident A</p> <p>Findings include:</p> <p>Resident A was observed during the noon meals of 3/6, 7, 8/2013, to be seated in her low wheel chair, dining on the same table top which was at her neck level. She was unable to see items positioned beyond her dinner plate.</p> <p>On 3/08/13 at 12:50 P.M., the Unit manager (UM) was asked to check the resident's position. She indicated "Well her table is too high for her but that's not her usual table. She sits at a lower table." The UM scanned the dining room and stated "well there isn't one in here but we can get that fixed."</p>	F000246	<p><b>F246</b> It is the practice of Willow Manor to always assure that residents receive reasonable accommodations of their needs.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i> The table height for resident A has been adjusted.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i> All residents have been reviewed during dining service to assure that the table height is correct. There were no other issues identified.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i> The Department Directors work with the residents during meal service as part of the Dining Room Program. The Directors have been in-serviced on</p>	04/11/2013			

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	<p>On 3/08/13 at 1:48 P.M. Maintenance supervisor was interviewed. He indicated "We don't have any adjustable tables but I cut one down before ( in the other unit dining room ) and can certainly do that again."</p> <p>3.1-3(v)(1)</p>		<p>assuring that residents are sitting at tables that appropriately accommodate their dining needs.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that will randomly review 5 residents during meal service to assure that residents are sitting at tables that accommodate their dining needs. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. Based on any recommendations changes will be made as necessary</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to provide services according to the plan of care for 1 of 5 residents reviewed for restorative, toileting and/or repositioning services.</p> <p>Resident A</p> <p>Findings include:</p> <p>Resident A was observed in a wheel chair on 3/06 for 3.75 hours from 9:30 A.M. to 1:15 P.M. and on 3/07 for 4 hours from 9:15 A.M. to 1:15 P.M. without position change or opportunity to toilet.</p> <p>The clinical record of Resident A was reviewed on 3/07/13 at 2:00 P.M. Diagnosis included but were not limited to left cerebral vascular accident (CVA), hypertension, deep vein thrombosis, hypothyroidism, and right leg cellulitis.</p> <p>There was a 3 day bowel and bladder assessment completed on 2/12/13. The summary and care plan</p>	F000282	<p><b>F282</b></p> <p><b>It is the practice of this facility to assure that the services are provided to the residents in accordance with the plans of care.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b> Resident A is now receiving services in accordance with the plan of care. This includes restorative, toileting, and positioning.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b> All residents have been reviewed to assure that all residents are receiving services in accordance with their individualized plan of care. Emphasis was related to restorative, toileting, and repositioning.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b> The nurses are responsible for assuring that the residents under</p>	04/11/2013	

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	<p>statement was " Patient incontinent specific times during the day during the bowel and bladder tracking of urine. Will plan to toilet patient before breakfast, before lunch, before supper, and before going to bed and at 5:00 A.M. every morning when getting up for the day."</p> <p>The Care plan since 6/15/12 and last updated on 3/1/13 indicated the resident had physical mobility impairment with transfers and had decreased mobility related to the CVA and did not self propel the wheel chair and directed repositioning.</p> <p>The CNA assignment sheets in use on 3/06 and 3/07/13 directed the resident was to be turned and repositioned, laid down after meals and toileted at 5:30 A.M., 8:30 A.M., 10:30 A.M., 1:30 P.M., 3:30 P.M., 5:30 P.M., and at bedtime.</p> <p>This federal tag relates to complaint IN00122536</p> <p>3.1-39(g)(2)</p>		<p>their care are provided services in accordance with their plan of care. Pertinent care issues are identified on the CNA assignment sheet. The nurses and CNAs have been in-serviced related to assuring that all services are provided in accordance with the resident's assessed needs. The emphasis during this in-service was toileting, restorative services, and repositioning. Please see below for monitoring.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 residents to assure that services are being provided to them in accordance with the plan of care. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed presented to the IDT team for correction</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>		

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F000309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow its policy on monitoring and administering stool softeners and/ or laxatives for 1 of 2 residents reviewed in the sample who met the criteria. Resident W</p> <p>Findings include:</p> <p>On 3/11/13 at 3:58 P.M., the clinical record for Resident W was reviewed. Resident W was admitted on 2/15/13, Diagnoses included but were not limited to, the following: history of falls, closed fracture of 2 ribs, and chronic constipation.</p> <p>During an interview on 3/4/13 at 3:05 P.M., Resident W stated, "I asked the day shift nurse for a Fleets enema because I had not had a bowel movement in 7 days. I was sick to my stomach and had cramping. I felt bad." Resident W indicated the nurse wanted to give her a suppository, but Resident W felt she</p>	F000309	<p><b>F309</b>  <b>It is the practice of Willow Manor to assure that our residents receive appropriate services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b>  Resident #W has been discharged home.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b>  All residents have been reviewed to assure that they are having routine BMs. Any resident having an episode of constipation will be treated in accordance with facility policy,</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p>	04/11/2013	

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	<p>needed an enema since it had been 7 days since her last BM. Resident W said, "I never did see the nurse again. She went home, and I told the evening shift nurse what I needed, and she got the Fleets enema for me."</p> <p>The Policy and Procedure of Administering Laxatives and Stool softeners for constipation was reviewed on 3/11/13 at 3:45 P.M. The procedures are listed below.</p> <p>"1. All bowel movements (BM's) will be recorded on the daily bowel movement record. Each shift will document the resident's bowel movement for that shift.</p> <p>2. ...BM records will be reviewed daily by the 3-11 nurse. Nurse will administer a stool softener or laxative as needed and as ordered by the doctor.</p> <p>3. When reviewing a BM record for 3 days, an indication of "0" would indicate that a stool softener or laxative should be administered unless contraindicated by the doctor.</p> <p>4. 11-7 shift nurse is responsible for following up on all stool softeners and laxatives given on prior shifts for results. If no results are indicated then a follow up stool softer or a laxative should be administered.</p>		<p>The facility believes that the current policy related to frequency of bowel movements and interventions to facilitate bowel movements is appropriate. Therefore, all nursing staff has been in-serviced related to following of the facility policy. The CNAs have been in-serviced related to assuring proper documentation of bowel movements. The nurses have been in-serviced related to monitoring of frequency of bowel movements and assuring that proper protocol is implemented if a resident is not having routine bowel movements. The Unit Managers will also be reviewing the documentation for bowel movements to assure that facility protocol is being followed.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that will be utilized to observe for the frequency of bowel movements and to assure that any episodes of constipation are treated in accordance with facility policy. The tool will randomly review 5 residents to assure that protocol is followed in the event the resident is not having routine bowel movements. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3.</p>		

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	<p>5. If a resident does not have a BM after prior interventions, a follow up call to the doctor should be competed within 24 hours of the first intervention."</p> <p>On 3/11/13 at 3:58 P.M., the clinical record for Resident W was reviewed. An Admission Assessment Form dated 2/15/13 documented that Resident W's last bowel movement was 2/14/13.</p> <p>Nurses Notes dated 2/21/13 at 4:45 P.M. indicated...ducolax suppository offered and refused. Resident requested a Fleets enema...doctor was notified of request and waiting for return call.</p> <p>Nursing Notes dated 2/21/13 at 5:10 P.M., indicated new orders received for administering Fleets enema once every day as needed for constipation.</p> <p>Nursing Notes dated 2/21/13 at 6:00 P.M. indicated Fleets enema administered as requested with results of a large BM.</p> <p>A care plan dated 2/20/13 addressed the problem of "Chronic Constipation".</p> <p>The goal outlined for the care plan was identified as "The resident will have soft formed stools every three days and exhibit no signs of discomfort."</p>		<p>Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed for the IDT team.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>	

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	<p>Interventions were as follows:</p> <p>"1. Monitor BM every shift, and record. If no BM for 3 days, administer laxative as ordered per facility bowel protocol.</p> <p>2. 2/20/13 Docolax suppository 1 as ordered.</p> <p>3. 2/21/13 Fleets enema as ordered."</p> <p>On 3/11/13 at 4:48 P.M., the Bowel Monitoring form was reviewed. The form documented no BM from the admission date of 2/15/13 until evening shift on 2/21/13, at which point Resident W had a large BM. The BM Form also documented that Resident W did not have a BM again until 4 days later on 2/25/13 during the midnight shift after a Docolax suppository.</p> <p>During an interview with LPN #16 on 3/12/13 at 12:05 P.M., LPN #16 indicated that if a resident had not had a BM within 2 -3 days, the resident would then be given Milk of Magnesia (MOM). If the MOM did not work, the resident would then be given a suppository. If the suppository did not work, then the resident would then be given an enema by the night shift nurse.</p> <p>During an interview with the DON on</p>						

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	<p>3/12/13 at 3:15 P.M., the DON indicated that a resident should not go longer than 3 days without a bowel movement.</p> <p>3.1-37(a)</p>			

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F000311 SS=E	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview and record review, the facility failed to provide repositioning, toileting and/or ambulation needs 2 days for 14 of 16 residents requiring those services. Resident A, Resident Z, Resident 129, Resident 156, Resident 165, Resident 54, Resident 55, Resident 20, Resident 118, Resident 96, Resident 8, Resident 71, Resident 35, Resident 100</p> <p>Findings include:</p> <p>1. Resident A was observed in a wheel chair on 3/06 for 3.75 hours from 9:30 A.M. to 1:15 P.M. and on 3/07 for 4 hours from 9:15 A.M. to 1:15 P.M. without position change or opportunity to toilet.</p> <p>The clinical record of Resident A was reviewed on 3/07/13 at 2:00 P.M. Diagnosis included but were not limited to left cerebral vascular accident (CVA), hypertension, deep vein thrombosis, hypothyroidism, and right leg cellulitis.</p>	F000311	<p><b>F311</b> <b>It is the practice of this facility to assure that residents receive services to maintain or improve residents' abilities.</b></p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b> Resident A is being toileted and repositioning in accordance with the plan of care. Resident Z is being ambulated in accordance with the plan of care or has the documentation related to refusals. Residents #129, #156, #165, #54, #55, #20, #118, #96, #8, #71, #35, and #100 are all receiving restorative services in accordance with the plan of care.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents have been reviewed to assure that services are being provided appropriately including toileting, ambulation, and repositioning and other restorative services. Restorative staffing has been reviewed and corrected to assure that services are being provided as planned.</p>	04/11/2013	

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	<p>There was a 3 day bowel and bladder assessment completed on 2/12/13. The summary and care plan statement was " Patient incontinent specific times during the day during the bowel and bladder tracking of urine. Will plan to toilet patient before breakfast, before lunch, before supper, and before going to bed and at 5:00 A.M. every morning when getting up for the day."</p> <p>The Care plan since 6/15/12 and last updated on 3/1/13 indicated the resident had physical mobility impairment with transfers and had decreased mobility related to the CVA and did not self propel the wheel chair and directed repositioning.</p> <p>The CNA assignment sheets in use on 3/06 and 3/07/13 directed the resident was to be turned and repositioned, laid down after meals and toileted at 5:30 A.M., 8:30 A.M., 10:30 A.M., 1:30 P.M., 3:30 P.M., 5:30 P.M., and at bedtime.</p> <p>2. Resident Z's clinical record was reviewed on 3/7/13 at 8:58 A.M. Diagnoses included but were not limited to: contractures of bilateral hands, non insulin depended diabetes mellitus, and mood disorder.</p>		<p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The nurses are responsible for assuring that the residents under their care are provided services in accordance with their plan of care. Pertinent care issues are identified on the CNA assignment sheet. The nurses and CNAs have been in-serviced related to assuring that all services are provided in accordance with the resident's assessed needs. The emphasis during this in-service was toileting, restorative services, and repositioning. The restorative staff has been in-serviced related to assuring that planned services are provided in accordance with the plan of care. The nursing services scheduler has been in-serviced related to assuring that restorative personnel are in the building in accordance with the facility staffing pattern. Please see below for means of monitoring.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to repositioning, toileting, and addition restorative programs. The Director of</p>		

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	<p>His current care plan had addressed, "nursing restorative walking related to: potential for decline in ability to walk (initiated 1/22/13)." Goal included, "Resident will be able to walk 150 feet with RW (rolling walker) with CG(contact guard) /Min assist (minimal assistance) times one daily through next review." Interventions included but were not limited to: document minutes on restorative grid, use appropriate assistive device, and for nurse to review restorative program quarterly or when a significant change in resident's status.</p> <p>On 3/11/13 at 10:55 A.M., Restorative CNA #1 was interviewed and indicated Resident Z had refused his restorative ambulation. She provided the March 2013 restorative nursing documentation for Resident Z. The March 2013 restorative record had included to walk resident 150 feet with a rolling walker with CG/minimal assist times one. Documentation was lacking of any ambulation exercises provided from 3/1/13 through 3/10/13 except on 3/7/13 when Restorative CNA # 1 had documented a R for refusal of ambulation. All other days from 3/1/13 -3/10/13 were left blank.</p>		<p>Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. Any recommendations will be reviewed with changes in interventions as needed.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>	

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	<p>On 3/11/13 at 11:00 A.M., during interview with Restorative CNA #1 she indicated the January and February restorative records were kept in the MDS (Minimum Data Set Assessment ) office.</p> <p>On 3/11/13 at 11:00 A.M., during interview with MDS nurse #1, she indicated she had January and February 2013 restorative records for Resident Z. The February and January restorative records were reviewed with MDS nurse #1 and Restorative CNA #1 at that time. The February 2013 ambulation record indicated 18 of 28 days were blank (ambulation had not been provided) and 1 day ambulation had been refused. The January 2013 ambulation record from initiation as of 1/23/13 to 1/31/13 ( a 9 day period) indicated Restorative ambulation had not been provided for 5 of 9 days (left blank).</p> <p>On 3/11/13 at 11:00 A.M., during interview with MDS nurse #1, she indicated MDS department assisted the restorative CNAs with the restorative program. She indicated the restorative program had 2 full time CNAs and a part time CNA that</p>			

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	<p>worked 2 days a week. She indicated a full time restorative CNA had recently quit. She also indicated that restorative CNAs at times are pulled off restorative nursing to work the floor as a CNA. She indicated the facility had been currently interviewing for a restorative position. She indicated Resident Z restorative program for walking had been ordered on 1/22/13.</p> <p>On 3/11/13 at 11:05 A.M., Restorative CNA #1 during interview indicated she was the only restorative staff at the facility today and would be unable to provide restorative services to all residents in the facility on restorative nursing program.</p> <p>On 3/11/13 at 11:10 A.M., Restorative CNA #1 indicated March 4 had been her 1st day as a Restorative CNA. She indicated she also had worked as restorative CNA on 3/6, 3/7, and 3/8/13. She indicated on 3/8/13, she had attended a meeting. She indicated she had attempted Resident Z's restorative services on 3/7/13 but the resident had refused. She indicated on 3/6/13, she was unable to provide or offer restorative services to Resident Z. She indicated she had been unable to get to him due to lack</p>						

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	<p>of time.</p> <p>On 3/12/13 at 2:00 P.M., Resident Z's Nurse Unit Manager was made aware of the lack of restorative services being provided from 1/23/13 through 3/10/13 for Resident Z. She indicated the MDS department managed the restorative program. She indicated she had been aware of the turnover of the facility's restorative staff and agreed there had been a lack of restorative services provided.</p> <p>3. On 3/11/13 at 11:10 A.M., Restorative CNA #1 during interview indicated, she had been unable to provide restorative services on 3/7/13, for the following residents: Residents #129, 156, 165, 55, 20, 118, and 96. She indicated she had been unable to provide restorative services for the following residents on 3/8/13 due to attending a meeting: Residents # 54, 156, 8, Z, 71, 35, 100, and 96.</p> <p>On 3/11/13 at 11:16 A.M., MDS Nurse #1 indicated a full time Restorative CNA#4 had left employment in November 2012 and the facility had been interviewing for her position. Part time CNA #3 had worked full time in December 2012 and the first 2 weeks of January 2013. She indicated she was a</p>				

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	<p>student and now had only been working 2 days a week. She indicated Restorative CNA #1 had started working as a restorative CNA on 3/4/13. MDS #1 was made aware that Resident Z had not been receiving restorative services he had been planned for. She provided no further information.</p> <p>This Federal tag relates to complaint IN00122536.</p> <p>3.1-38(a)(2)</p>				

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F000318 SS=E	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on interview and record review, the facility failed to ensure range of motion (ROM) exercises were provided for 3 of 3 resident's reviewed for range of motion exercises who met the criteria for restorative services and twelve additional residents who were to receive restorative services. Resident Z, Resident X, Resident Y, Resident 129, Resident 156, Resident 165, Resident 54, Resident 55, Resident 20, Resident 118, Resident 96, Resident 8, Resident 71, Resident 35, Resident 100</p> <p>Findings included:</p> <p>1. Resident Z's clinical record was reviewed on 3/7/13 at 8:58 A.M. Diagnoses included, but were not limited to: contractures of bilateral hands, non insulin depended diabetes mellitus, and mood disorder.</p>	F000318	<p><b>F318</b></p> <p><b>It is the practice of this facility to assure that residents receive appropriate services to increase or prevent further deterioration in range of motion.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b> Resident #Z is currently receiving ROM services in accordance with the plan of care Resident #X is currently receiving ROM services in accordance with the plan of care. Resident Y is currently receiving ROM services in accordance with the plan of care. Residents #129, #156, #165, #54, #55, #20, #118, #96, #8, #71, #35, and #100 are currently receiving restorative services in accordance with the plan of care.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b> All residents have been reviewed related to ROM programs. The residents that are identified as</p>	04/11/2013	

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	<p>His current care plan had addressed the nursing restorative program with "AROM (active range of motion) related to potential for decline in ROM (range of motion) with potential for contracture formation (initiated 1/22/13)." Goals were: "Resident will perform : AROM to BLE's (bilateral lower extremities) with 2 lb wt (weight), hip flex (flexion)/ext (extension), hip and(abduction) /add (adduction), knee flex/ext ankle flex/ext times 10 reps (repetitions) daily through next review."</p> <p>On 3/11/13 at 10:55 A.M., Restorative CNA #1 was interviewed and indicated Resident Z had refused his range of motion exercises. She provided the March 2013 restorative nursing documentation for Resident Z. The March 2013 restorative record had included AROM to BLE's with a 2 lb wt for the hip, knee , and ankle. Exercises included flexion, extension, abduction, and adduction x 10 repetitions. The record also had included PROM (Passive Range of Motion) to right and left hand 2 times with 10 repetitions. Staff were to encourage resident to attempt AAROM (active assistive range of motion) first and if resident was unable to perform staff were to</p>		<p>needing ROM are receiving the services in accordance with the plan of care.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> Through a combination of Therapy and Nursing, residents will be screened for range of motion at the time of admission and on a quarterly basis. If a resident is shown to have a decreased range of motion, an appropriate program will be established. The nursing staff and restorative staff have been in-serviced related to the importance of providing range of motion in correlation with the plan of care. The nursing scheduler has also been in-serviced related to assuring that adequate restorative personnel are scheduled so that all residents that require range of motion receive the services.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 residents for range of motion services. The</p>		

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	<p>perform PROM. Documentation was lacking of any range of motion exercises provided from 3/1/13 through 3/10/13 except on 3/7/13 when Restorative CNA # 1 had documented a R for refusal of exercises.</p> <p>All other days from 3/1/13 -3/10/13 were left blank.</p> <p>On 3/11/13 at 11:00 A.M., during interview with Restorative CNA #1 she indicated the January and February restorative records were kept in the MDS (Minimum Data Set Assessment ) office.</p> <p>On 3/11/13 at 11:05 A.M., Restorative CNA #1 during interview indicated she was the only restorative staff at the facility today and would be unable to provide restorative services to all residents in the facility on the restorative nursing program</p> <p>On 3/11/13 at 11:10 A.M., Restorative CNA #1 indicated March 4 had been her 1st day as a Restorative CNA. She indicated she also had worked as restorative CNA on 3/6, 3/7, and 3/8/13. She indicated on 3/8/13, she had attended a meeting. She indicated she had attempted Resident Z's restorative services on 3/7/13 but</p>		<p>tool will observe the service provided as well as observe the documentation related to the provision of services. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>				

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	<p>the resident had refused. She indicated on 3/6/13, she was unable to provide or offer restorative services to Resident Z. She indicated she had been unable to get to him due to lack of time.</p> <p>On 3/11/13 at 11:10 A.M., during interview with the Restorative CNA #1 she indicated she had been unable to provide restorative services on 3/7/13 for the following residents: Residents #129, 156, 165, 55, 20, 118, and 96. She indicated she had been unable to provide restorative services for the following residents on 3/8/13 due to attending a meeting: Residents # 54, 156, 8, Z, 71, 35, 100, and 96.</p> <p>On 3/11/13 at 11:00 A.M., during interview with MDS Nurse #1, she indicated she had had January and February 2013 restorative records. The February and January restorative records were reviewed with MDS nurse #1 an Restorative CNA #1 at that time. The February 2013 ROM record indicated 15 minutes of PROM(program initiated on 2/12/13) to the hands had 10 days left blank of the 16 days. The February 2013 ROM record for AROM to the lower extremities indicated 1 day the resident had refused. Eighteen of</p>				

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	<p>twenty eight days were left blank for AROM to lower extremities. The January 2013 restorative record addressed AROM to lower extremities and had been initiated on 1/23/13. From 1/23/13 -1/31/13, 1 day refusal had been documented and 5 of the 9 day period had been left blanked.</p> <p>On 3/11/13 at 11:00 A.M., during interview with MDS Nurse #1, she indicated MDS department assisted the restorative CNAs with the restorative program. She indicated the restorative program had 2 full time CNAs and a part time CNA that had been working 2 days a week. She indicated a full time Restorative CNA had recently quit. She also indicated that Restorative CNAs at times were pulled off restorative nursing to work the floor as CNAs. She indicated the facility had been currently interviewing for a restorative position. She indicated Resident Z's restorative program for hands had been initiated on 2/12/13 the ROM for lower extremities had been initiated on 1/22/13.</p> <p>On 3/11/13 at 11:16 A.M., MDS Nurse #1 indicated full time</p>				

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	<p>Restorative CNA #4 had left employment in November and facility had been interviewing for her position. Part time CNA #3 had worked full time in December 2012 and the first 2 weeks of January 2013. She indicated she was a student and now had been working 2 days a week. She indicated Restorative CNA #1 had started working as a restorative CNA on 3/4/13. MDS Nurse #1 was made aware of that Resident Z had not been receiving restorative services he had been planned for. She provided no further information.</p> <p>On 3/12/13 at 2:00 P.M., Resident Z's Nurse Unit Manager was made aware of the lack of restorative services being provided from 1/23/13 through 3/10/13 for Resident Z. She indicated the MDS department managed the restorative program. She indicated she had been aware of the turnover of the facility's restorative staff and agreed there had been a lack of restorative services provided.</p> <p>2. On 3/10/13 the clinical record of Resident X was reviewed. Diagnoses included, but were not limited to, the following: late effects of cerebrovascular disease and lack of</p>				

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	<p>coordination. A "Restorative Nursing" form from January, February and March of 2013 were reviewed. The form recorded the resident was to "perform,allow staff to perform PROM (passive range of motion) to lower extremities 10 reps (repetitions) x 2 sets." The following was observed on the restorative nursing documentation log: for the 31 days in January, 26 days were left blank; for the 28 days in February, 20 were left blank and for the 10 days of the month, 8 days were left blank.</p> <p>On 3/11/13 at 12 P.M., the MDS (Minimum Data Set Assessment) coordinator was interviewed regarding the restorative for Resident X. She indicated that the Restorative Aide was off today and the floor staff is to perform restorative services when the Restorative CNA (Certified Nursing Assistant) is off. She indicated at this that, the resident did not have a decline in his range of motion.</p> <p>On 3/11/13 at 12:15 P.M., CNA #30 was interviewed. She indicated she was working on the hall today with Resident X. She indicated the resident does get ROM (range of motion) daily with his baths in the morning. She indicated that is documented in the ADL (Activities of</p>						

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	<p>Daily Living) book. At that time, CNA #30 checked her CNA assignment sheet. She was interviewed as to what specific ROM (range of motion) the resident receives. She indicated "Oh, he must be a level 1, that means that the restorative staff does ROM on him." She indicated a "Level 2" means the CNAs do the ROM on residents. CNA #30 indicated there were "no specifics" for the CNAs to perform Resident X's range of motion. She indicated "he just gets in the morning with his daily baths."</p> <p>On 3/11/13 at 3:55 P.M., the DON was interviewed. She indicated the resident is on the PROM Level 1, which is designated for the restorative CNAs to do. She indicated the resident is also on the Level 2 program, which is designated for floor staff to perform for oral care/hygiene and bed mobility. The DON indicated the resident is to receive PROM to lower extremities for 10 reps x 2 sets. The DON indicated the PROM is to be done daily. At that time, she reviewed the January, February and March 2013 Restorative Nursing records and indicated these months of documentation were incomplete.</p> <p>3. On 3/11/13 at 11:00 A.M., Resident</p>			

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	<p>Y's clinical record was reviewed. Resident Y was admitted to the facility on 12/19/12. Diagnoses included, but were not limited to, the following: Alzheimer's disease, cerebrovascular disease, atrial fibrillation, dementia with behavioral disturbances, and anemia . No current Minimal Data Assessment Summary was available.</p> <p>Resident Y's current care plan for Nursing Restorative Program initiated on 12/19/12, addressed active range of motion related to a potential for decline in range of motion and a potential for a contracture formation. Interventions were as follows: 1. Document minutes on restorative grid. 2. Nurse to review program quarterly and with significant change in status. 3. Observe and report to nurse pain, declines, joint stiffness, swelling. 4. Provide verbal cues and encouragement, hands on assistance as needed for task segmentation.</p> <p>On 3/11/13 at 11:10 P.M., restorative nursing plan was as follows: Resident to perform active range of motion to upper and lower extremities, 10 repetitions times 2 sets. May participate in group exercises.</p> <p>On 3/11/13 at 11:15 P.M.,</p>			

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	<p>Restorative Nursing's Range of Motion documentation form was reviewed. The Form did not contain documentation that range of motion services had been provided for Resident Y for 5 days during March, 14 days during January, 12 days during February of 2013.</p> <p>During an interview on 3/12/13 at 2:46 P.M., RN #16 indicated that any resident scheduled for Restorative Nursing should have had Range Of Motion services everyday including week-ends.</p> <p>This Federal tag relates to Complaint IN00122536</p> <p>3.1-42(a)(2)</p>			

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure that the residents' environment in 2 of 2 shower rooms located on E Hall were free of potentially hazardous materials that were being stored in unlocked cabinets. These hazardous materials had the potential to impact 4 (Resident #40, Resident #24, Resident #54 and Resident #19) of the 22 residents residing on E Hall who were cognitively impaired.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 3/4/13 at 11:24 A. M., an unlocked, three drawer cabinet, located in the men's shower room on E hall contained the following items: McKesson's Shaving Cream, Mc Knesson's Fluoride Toothpaste, Peri Fresh Perineal Cleaner, Fresh Moment After Shave Lotion, and Dispatch Cleaner. In the women's shower room on E Hall, an unlocked cabinet contained</p>	F000323	<p><b>F323</b> It is the practice of Willow to assure that the environment is safe for the residents.</p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b> No specific residents were identified. The two shower rooms identified are locked and monitored frequently</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents could potentially be affected. All areas where chemicals are stored are secured and monitored frequently</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> All staff has been in-serviced related to assuring that all potentially hazardous products are kept in locked areas that are not accessible to residents. Nurses will monitor via rounds on their designated shifts to assure</p>	04/11/2013			

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	<p>the following items: Effervescent Denture Cleaner, Evoke Shaving Cream, PeriGaurd, Peri Fresh Perineal Cleaner, Ultra Sure Anti-perspirant, Instant Hand Sanitizer, and Evoke Baby Powder.</p> <p>Warning Labels located on the packaging of the above listed items were as follows:</p> <ol style="list-style-type: none"> <li>1. McKesson's Shaving Cream ..."Keep out of reach of children".</li> <li>2. Mc Knesson's Fluoride Toothpaste ..."Keep out of the reach of children under 6 years of age. If you accidentally swallow more than used for brushing get medical help or contact the Poison Control Center immediately".</li> <li>3. Peri Fresh Perineal Cleaner ..".Avoid contact with eyes. Keep out of reach of children."</li> <li>4. Fresh Moment After Shave Lotion ..."Keep out of the reach of children."</li> <li>5. Effervescent Denture Cleaner..."Warning. Do not place tablets or denture cleaning solution in mouth. Keep this product out of the reach of children. In case of accidental ingestion, seek professional assistance or contact the Poison Control Center immediately."</li> <li>6. Dispatch Cleaner ..."if in eyes, open eye and rinse slowly and gently with water for 15 to 20 minutes...Call</li> </ol>		<p>that chemicals are stored in accordance with facility policy.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that will be utilize to randomly check areas of the facility where potentially hazardous chemicals are stored to assure that they are secure. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the regularly scheduled meeting following the completion of the tool with recommendations for additional interventions as needed.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>				

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	<p>Poison Control Center or a doctor, or when going for treatment have product label with you."</p> <p>7. Ultra Sure Anti-perspirant.."Keep out of reach of children."</p> <p>8. PeriGaurd.."Avoid contact with eyes...Keep out of the reach of children...In case of accidental ingestion contact a physician or call Poison Control Center right away."</p> <p>During an interview with CNA #18 on 3/4/13 at 3:15 P.M., CNA #18 indicated that all personal care hygiene products should not be left out in the shower rooms. CNA #18 indicated that personal care hygiene products should be locked up after the showers are completed.</p> <p>During an interview on 3/5/13 at 9:58 A.M., RN #18 indicated that she did not know that the cabinets were in the shower rooms and that the products located in the cabinets should be locked up.</p> <p>3.1-45(a)(1)</p>				

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F000329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure duplicate hypnotic therapy was not provided for 1 of 10 residents who met the criteria for psychotropic medications. Resident Z</p> <p>Findings include:</p> <p>Resident Z's clinical record was reviewed on 3/7/13 at 8:58 A.M. Diagnoses included but were not</p>	F000329	<p><b>F329</b></p> <p><b>It is the practice of Willow Manor to assure that medications are reviewed for appropriateness and in accordance with the physician's order.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #Z medication has been reviewed, the physician contacted, and appropriate adjustments made.</p>	04/11/2013			

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	<p>limited to: contractures of bilateral hands, non insulin depended diabetes mellitus, and mood disorder. Resident Z had been admitted to the facility on 1/1/13.</p> <p>His admission physician orders dated 1/1/13 included Restoril (sleeping medication) 30 mg at hs (bedtime) and Tylenol PM (bedtime) 500/25 (Tylenol 500 mg/Benadryl 25 mg at hs.</p> <p>A pharmacy note from the Pharmacist review log dated 1/24/13 included but was not limited to: "Rest (Restoril) + APAP (Tylenol) PM (bedtime)? "</p> <p>A note to the attending physician from the pharmacist dated 1/24/13 included the following: " RE: Restoril 30 mg 1 PO (orally) Q (every) HS as well as Tylenol PM Q HS. The resident is currently receiving routine doses of this medication. Please note that the Restoril 30 mg is dosed above the usual geriatric dosage of 7.5 mg of Restoril per day. Although this resident may well be suited for Restoril 30 mg per day. CMS guidelines question the use of more than 7.5 mg of Restoril per day in the geriatric population. With this in mind, please consider a trial gradual dose reduction to 7.5 mg 1 PO Q HS</p>		<p><b>Other residents that have the potential to be affected have been identified by:</b> All residents that take hypnotic medications have been reviewed to assure appropriate..</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The nurses have been in-serviced related to the use of hypnotic medications and their appropriateness. In addition, the interdisciplinary team will review all new admissions/returns from hospital as well as reviewing physician orders each business morning to assure that any orders related to hypnotic medications are appropriate. Nursing Management has also has a binder that tracks hypnotics for ongoing review for reduction and elimination.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to hypnotic drug administration. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be</p>		

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	<p>PRN (if needed) for insomnia..."</p> <p>A physician's telephone order dated 1/28/13 indicated, "D/C (discontinue) Restoril 30 mg 1 po Q HS et Start Restoril 7.5 mg 1 po @ HS PRN for insomnia."</p> <p>A physician's telephone order dated 1/29/13 indicated, "Clarification order: Restoril 7.5 mg 1 po @ HS PRN for insomnia x's 7 days then re-eval (re-evaluate)."</p> <p>A physician's telephone order dated 2/6/13 indicated, " D/C Restoril 7.5 mg 1 po @ HS PRN for insomnia due to non- use."</p> <p>On 3/11/13 at 9:30 A.M., Resident Z's Nurse Unit Manager was made aware the resident had been receiving duplicate hypnotics daily from admission until 1/28/13 after a pharmacy recommendation on 1/24/13. The Nurse Unit Manager was made aware the resident did not take prn Restoril after the routine bedtime medication had been discontinued. She indicated at that time she understood the problem of duplicate hypnotic medication. She also indicated Resident Z had continued to take Tylenol PM. She indicated that Benadryl was not a</p>		<p>immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>		

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	<p>drug usually recommended for the elderly.</p> <p>On 3/12/13 at 1:50 P.M., the facility's drug book entitled, PDR (Physician's Drug Reference) 2013 edition Nurse's Drug Handbook was reviewed with Resident Z's Nurse Unit Manager in regard to the drugs of Restoril and Tylenol PM. On page 827, the drug Restoril had warnings and precautions listed. The warnings included but were not limited to: "Initiate only after careful evaluation; failure of insomnia to remit after 7-10 days of treatment may indicate primary psychiatric and/ or medical illness. Worsening of insomnia and emergence of thinking or behavior abnormalities may occur especially in the elderly; use lowest possible effective dose..."</p> <p>3.1-48(a)(3)</p>				

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F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review the facility failed to provide adequate nursing staff for timely resident call response, food delivery, restorative and activity of living support services for residents on 3 of 4 units. Unit CD Unit EF</p> <p>Findings include:</p> <p>1. On the CD unit, care of residents was observed on 3/06/13 and 3/07/13 in the dining room. On each day between 11:55 A.M. and 12:15 P.M.</p>	F000353	<p><b>F353</b></p> <p><b>It is the practice of Willow Manor to assure that there is sufficient staff to assure that the needs of the residents are met.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b> Resident Z, X, and Y are all receiving services in accordance with their plan of care. The scheduling of sufficient staff has been addressed so that the resident's needs are met in a</p>	04/11/2013	

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	<p>there were 25 to 30 residents to be served their meals by 2 nursing staff. Other staff were occupied in the halls getting residents up and ready for the meal which was ready to be served. During both days from 9:15 A.M. to 1:30 P.M., Resident A was observed for care and position change. She was observed to be unable to self propel her wheel chair or reposition herself in it. The resident was in a wheel chair on 3/06 for 3.75 hours from 9:30 A.M. to 1:15 P.M. and on 3/07 for 4 hours from 9:15 A.M. to 1:15 P.M. without position change or an opportunity to toilet. The nurse aid assignment sheets for CD unit, on those days, were reviewed on 3/07/13 at 10 A.M. They directed that the resident was to be laid down after meals and toileted at 10:30 A.M.</p> <p>On 3/08/13 at 12:25 P.M., CD dining room meal service, which was supposed to have begun at 12:00 P.M., was delayed. The CNA servers for the meal were occupied passing trays in the halls at that time. Meal service in the dining room began at 12:29 P.M. and the last resident was served at 12:51 P.M.</p> <p>2. During 8 of 20 residents confidential resident interviews, on the CD and EF units, residents</p>		<p>timely manner.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> All residents could potentially be affected. The staffing has been reviewed to assure that adequate staff is available to meet the needs of the residents. Please see systematic changes below to prevent reoccurrence</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The Administrator and Director of Nursing have reviewed staffing and established an acceptable staffing pattern that will meet the needs of the residents. The clinical scheduler has been in-serviced related to assuring that nursing personnel is in the building in accordance with the established staffing pattern. All nursing personnel have been in-serviced related to assuring that resident's needs are met including toileting, positioning, restorative services, dining services, and answering of call lights. It has been reinforced with nurses that they too are capable</p>				

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	<p>indicated there was not sufficient staff to provide services.</p> <p>Their comments included:</p> <p>"...staff have the most problem ...getting the food out on time...very seldom on time...worse at the supper meal it's after 6 PM when we get it and it's supposed to be at 5:15 P.M."</p> <p>" I put my call light on and they can't get here and to tell the truth I have accidents over it. If I would go myself I could easily get there, go and come back before they ever answer my light..."</p> <p>"...don't have enough people passing food out in the dining room especially at supper. We wait well over a half hour until we get served."</p> <p>"...They have cut down staff. When you call for someone it takes a long time to get here, about 1/2 hr sometimes.</p> <p>"Staff answer a resident call light, ask resident to wait and promise to come back but don't return."</p> <p>"Pretty good staff really but they are short handed...can't get ice water here."</p>		<p>of responding to resident's needs. Please see below related to ways of monitoring the staffing pattern.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly interviews residents, families, and/or staff. The tool will have questions related to staffing and meeting of residents' needs. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>		

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	<p>"At night there are only 2 CNAs on the night shift. There are call ins and it depends on if there is anyone to replace them with. Happens once a week on average."</p> <p>"...need more help...sometimes work the whole hall with 3 CNAs and 1 nurse and most patients need 2 CNAs to help them. We also have people who have to be fed and on the 2 to 10 shift there is only 2 aides working " with the same residents who have the same needs.</p> <p>"...need more CNAs. Haven't timed it but it takes a long time. Sometimes ...staff won't get here so have to go myself."</p> <p>3. Three of 3 family members, interviewed confidentially, indicated there was insufficient nursing staff.</p> <p>Their comments included:</p> <p>"(name of resident) fell (toileting alone)...fractures in several places...goes back to not having enough staff. They just didn't get to (name) in time to keep (name)from falling."</p> <p>"they can't deliver trays because they</p>						

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	<p>don't have enough staff and the food gets cold. They want to get it delivered but they can't. Can hear call lights going off for a long time...weekends is the worst."</p> <p>"need more staff especially in the evening...a problem for about a month."</p> <p>4. There were 15 of 20 staff interviewed from 3 different departments regarding care and services and work load. Those responding negatively were located on the CD and EF units.</p> <p>Their comments included but were not limited to the following:</p> <p>"Residents have to wait their turn with call lights but that could be 1/2 hour."</p> <p>"Need more help to put people to bed and answer lights on both days and evenings."</p> <p>"Not enough help to feed at supper and help reposition people. Two of us have to work together and so on many nights there isn't anyone left to take care of lights on the halls and the lights get ahead of us."</p> <p>"On evenings 2 of us are working in a</p>				

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	<p>room and other residents are putting their lights on. Resident T has got wet waiting for us and that really makes me feel bad."</p> <p>"Only Cans can answer lights most of our nurses can't. I guess they do have more responsibilities."</p> <p>"In our department (non- nursing) we can't toilet or reposition residents and when we need something the Cans can't come to help so if its really a problem we have to take the resident back to the unit and get help but we have to leave other residents waiting for us.(department renders service to more than 1 resident at a time). We do not have courier or transport service to contact with a walky talky to take residents... We have thought we need a CNA in our department for when residents have a care problem we could handle it. "There must be a way to fix this."</p> <p>"CNAs are too busy to get people up in time or toileted in time to get them to (our scheduled service). A lot of the residents require 2 people and they only have one so residents have to wait or are late or don't come."</p> <p>"When the CNAs are tied up smoking residents there is only one CNA left</p>			

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	<p>on the hall and many (residents) need 2 to transfer and lights start going off and are backed up..we are still trying to get people up for a meal and we are being hollered for, to go to the dining room to help pass trays...so no water gets passed. On 2-10 they say they can't get showers done but you are in trouble if you say you can't get them done."</p> <p>"Those CNAs work hard. They are always wanted in different places at the same time and the halls get lit up with residents calling. I couldn't work like that I'd be a wreck."</p> <p>"....no we don't but I'll get in trouble for saying it but I can't lie we have to cut a lot of corners."</p> <p>5. The nursing staffing schedule for the month of March 2013 was reviewed on 3/12/13. Staffing was at planned levels throughout the survey. The Medical Records staff person, who posted and amended schedules, was interviewed on 3/08/13 at 1:30 P.M. She indicated that with rare exception call ins were replaced promptly unless they had been scheduled extra.</p>				

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	<p>6. Resident Z's clinical record was reviewed on 3/7/13 at 8:58 A.M. Diagnoses included, but were not limited to: contractures of bilateral hands, non insulin depended diabetes mellitus, and mood disorder.</p> <p>His current care plan had addressed the nursing restorative program with "AROM (active range of motion) related to potential for decline in ROM (range of motion) with potential for contracture formation (initiated 1/22/13)." Goals were: "Resident will perform : AROM to BLE's (bilateral lower extremities) with 2 lb wt (weight), hip flex (flexion)/ext (extension), hip and(abduction) /add (adduction), knee flex/ext ankle flex/ext times 10 reps (repetitions) daily through next review."</p> <p>On 3/11/13 at 10:55 A.M., Restorative CNA #1 was interviewed and indicated Resident Z had refused his range of motion exercises. She provided the March 2013 restorative nursing documentation for Resident Z. The March 2013 restorative record had included AROM to BLE's with a 2 lb wt for the hip, knee , and ankle. Exercises included flexion, extension, abduction, and adduction x 10 repetitions. The record also had included PROM (Passive Range of</p>						

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	<p>Motion) to right and left hand 2 times with 10 repetitions. Staff were to encourage resident to attempt AAROM (active assistive range of motion) first and if resident was unable to perform staff were to perform PROM. Documentation was lacking of any range of motion exercises provided from 3/1/13 through 3/10/13 except on 3/7/13 when Restorative CNA # 1 had documented a R for refusal of exercises.</p> <p>All other days from 3/1/13 -3/10/13 were left blank.</p> <p>On 3/11/13 at 11:00 A.M., during interview with Restorative CNA #1 she indicated the January and February restorative records were kept in the MDS (Minimum Data Set Assessment ) office.</p> <p>On 3/11/13 at 11:05 A.M., Restorative CNA #1 during interview indicated she was the only restorative staff at the facility today and would be unable to provide restorative services to all residents in the facility on the restorative nursing program.</p> <p>On 3/11/13 at 11:10 A.M., Restorative CNA #1 indicated March 4 had been her 1st day as a Restorative CNA.</p>			

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	<p>She indicated she also had worked as restorative CNA on 3/6, 3/7, and 3/8/13. She indicated on 3/8/13, she had attended a meeting. She indicated she had attempted Resident Z's restorative services on 3/7/13 but the resident had refused. She indicated on 3/6/13, she was unable to provide or offer restorative services to Resident Z. She indicated she had been unable to get to him due to lack of time.</p> <p>On 3/11/13 at 11:00 A.M., during interview with MDS Nurse #1, she indicated she had had January and February 2013 restorative records. The February and January restorative records were reviewed with MDS nurse #1 an Restorative CNA #1 at that time. The February 2013 ROM record indicated 15 minutes of PROM (program initiated on 2/12/13) to the hands had been provided on 6 days and 10 days were left blank of the 16 days. The February 2013 ROM record for AROM to the lower extremities indicated day the resident had refused. Eighteen days of twenty eight days were left blank for AROM to lower extremities. The January 2013 restorative record addressed AROM to lower extremities and had been initiated on 1/23/13. From 1/23/13 -1/31/13, AROM were</p>			

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	<p>documented as a 1 day refusal and 5 of the 9 day period had been left blanked.</p> <p>On 3/11/13 at 11:00 A.M., during interview with MDS Nurse #1, she indicated MDS department assisted the restorative CNAs with the restorative program. She indicated the restorative program had 2 full time CNAs and a part time CNA that had been working 2 days a week. She indicated a full time Restorative CNA had recently quit. She also indicated that Restorative CNAs at times were pulled off restorative nursing to work the floor as CNAs. She indicated the facility had been currently interviewing for a restorative position. She indicated Resident Z's restorative program for hands had been initiated on 2/12/13 the ROM for lower extremities had been initiated on 1/22/13.</p> <p>On 3/11/13 at 11:16 A.M., MDS Nurse #1 indicated full time Restorative CNA #4 had left employment in November and facility had been interviewing for her position. Part time CNA #3 had worked full time in December 2012</p>			

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	<p>and the first 2 weeks of January 2013. She indicated she was a student and now had been working 2 days a week. She indicated Restorative CNA #1 had started working as a restorative CNA on 3/4/13. MDS Nurse #1 was made aware of that Resident Z had not been receiving restorative services he had been planned for. She provided no further information.</p> <p>On 3/12/13 at 2:00 P.M., Resident Z's Nurse Unit Manager was made aware of the lack of restorative services being provided from 1/23/13 through 3/10/13 for Resident Z. She indicated the MDS department managed the restorative program. She indicated she had been aware of the turnover of the facility's restorative staff and agreed there had been a lack of restorative services provided.</p> <p>7. On 3/10/13 the clinical record of Resident X was reviewed. Diagnoses included, but were not limited to, the following: late effects of cerebrovascular disease and lack of coordination. A "Restorative Nursing" form from January, February and March of 2013 were reviewed. The form recorded the resident was to "perform,allow staff to perform PROM</p>			

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	<p>(passive range of motion) to lower extremities 10 reps (repetitions) x 2 sets." The following was observed on the restorative nursing documentation log: for the 31 days in January, 26 days were left blank; for the 28 days in February, 20 were left blank and for the 10 days of the month, 8 days were left blank.</p> <p>On 3/11/13 at 12 P.M., the MDS (Minimum Data Set Assessment) coordinator was interviewed regarding the restorative for Resident X. She indicated that the Restorative Aide was off today and the floor staff is to perform restorative services when the Restorative CNA (Certified Nursing Assistant) is off. She indicated at that time, the resident did not have a decline in his range of motion.</p> <p>On 3/11/13 at 12:15 P.M., CNA #30 was interviewed. She indicated she was working on the hall today with Resident X. She indicated the resident does get ROM (range of motion) daily with his baths in the morning. She indicated that is documented in the ADL (Activities of Daily Living) book. At that time, CNA #30 checked her CNA assignment sheet. She was interviewed as to what specific ROM (range of motion) the resident receives. She indicated</p>			

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	<p>"Oh, he must be a level 1, that means that the restorative staff does ROM on him." She indicated a "Level 2" means the CNAs do the ROM on residents. CNA #30 indicated there were "no specifics" for the CNAs to perform Resident X's range of motion. She indicated "he just gets in the morning with his daily baths."</p> <p>On 3/11/13 at 3:55 P.M., the DON was interviewed. She indicated the resident is on the PROM Level 1, which is designated for the restorative CNAs to do. She indicated the resident is also on the Level 2 program, which is designated for floor staff to perform for oral care/hygiene and bed mobility. The DON indicated the resident is to receive PROM to lower extremities for 10 reps x 2 sets. The DON indicated the PROM is to be done daily. At that time, she reviewed the January, February and March 2013 Restorative Nursing records and indicated these months of documentation were incomplete.</p> <p>8. On 3/11/13 at 11:00 A.M., Resident Y's clinical record was reviewed. Resident Y was admitted to the facility on 12/19/12. Diagnoses included, but were not limited to, the following: Alzheimer's disease,</p>						

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	<p>cerebrovascular disease, atrial fibrillation, dementia with behavioral disturbances, and anemia . No current Minimal Data Assessment Summary was available.</p> <p>Resident Y's current care plan for Nursing Restorative Program initiated on 12/19/12, addressed active range of motion related to a potential for decline in range of motion and a potential for a contracture formation. Interventions were as follows: 1. Document minutes on restorative grid. 2. Nurse to review program quarterly and with significant change in status. 3. Observe and report to nurse pain, declines, joint stiffness, swelling. 4. Provide verbal cues and encouragement, hands on assistance as needed for task segmentation.</p> <p>On 3/11/13 at 11:10 P.M., Restorative nursing plan was as follows: Resident to perform active range of motion to upper and lower extremities, 10 repetitions times 2 sets. May participate in group exercises.</p> <p>On 3/11/13 at 11:15 P.M., Restorative Nursing's Range of Motion documentation form was reviewed. The Form did not contain documentation that range of motion</p>				

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	<p>services had been provided for Resident Y for 5 days during March, 14 days during January, 12 days during February of 2013.</p> <p>During interview on 3/12/13 at 2:46 P.M., RN # 16 indicated that any resident scheduled for Restorative Nursing should have had Range of Motion services everyday including week-ends.</p> <p>9. On 3/11/13 at 11:10 A.M., during interview with Restorative CNA #1, she indicated she had been unable to provide restorative services on 3/7/13 for the following residents: Residents #129, 156, 165, 55, 20, 118, and 96. She indicated she had been unable to provide restorative services for the following residents on 3/8/13 due to attending a meeting: Residents # 54, 156, 8, Z, 71, 35, 100, and 96.</p> <p>This federal tag relates to complaint IN00122536.</p> <p>3.1-17(a)</p>						

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F000364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to ensure that residents receiving food service in their rooms were being served food at the preferred temperatures for 1 of 1 test trays sampled.</p> <p>On 3/6/13 at 12:20 P.M., CNA #17 indicated that she had already delivered the food trays on E hall and was in the process of delivering the last 3 food trays on F hall.</p> <p>On 3/6/13 at 12:30 P.M., the last tray on E &amp; F hall was used as a test tray. The temperatures of food on the plate were checked with a thermometer obtained from the kitchen. The temperatures were as follows:</p> <ol style="list-style-type: none"> <li>1. Spinach 80 degrees</li> <li>2. Potatoes 102 degrees</li> <li>3. Meat Patty with gravy 90 degrees</li> <li>4. Coffee 100 degrees</li> <li>5. Milk 40 degrees</li> </ol> <p>During an interview with the Food Service Manager (FSM) on 3/12/13 at 11:50 A.M., the FSM indicated that a</p>	F000364	<p><b>F364</b> It is the practice of Willow Manor to all food served to the residents is served at proper temperatures.</p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b> No specific residents were identified. The food temperatures as being monitored as part of the serving and delivery process</p> <p><b>Other residents that have the potential to be affected have been identified by:</b> Potentially all residents could be affected. Please see systematic changes below to prevent reoccurrence.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> All dietary staff has been in-serviced related to assuring that when the meals leave the dietary department that they are at the appropriate temperature. The nursing staff has been</p>	04/11/2013			

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	<p>past complaint had been received about the food not being hot when it was delivered. The FSM indicated that she had checked the temperature log book for that day and the temperatures documented were all fine. The FSM indicated she would eat 2 to 3 times a week at the end of the meal service to ensure the food was still hot and palatable. The FSM said, "The goal is, food trays delivered to the rooms should be 140."</p> <p>3.1-21(a)(2)</p>		<p>in-serviced related to timely service of the trays once they are received on the hallways. The Dietary Manager will be responsible for monitoring and assuring that the food is at the appropriate temperatures when served to the residents. The Unit Managers will be assisting to assure that nursing personnel serves residents' trays in a timely manner to assure proper temperatures.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 hall trays on each unit to assure appropriate temperatures. The temperatures will be taken after the last resident tray is passed. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed for additional interventions.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>		

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure that sanitary conditions for food preparation and storage were not met in 2 of 2 kitchens toured. These conditions had the potential to impact 130 residents residing in the facility.</p> <p>Findings include:</p> <p>On 3/4/13 at 10:45 A.M., the first kitchen toured prepared food for A,B,C and D Halls in the facility. Observed in the walk in freezer on the second shelf was an unwrapped, exposed ham with no date indicating when the ham had been opened. The exposed ham's surface was observed to be dried and a white substance had formed over the end of the meat. The Dietary Service Manager (DSM) said, "The ham needs to be pitched. It should have been sealed." Located on the second shelf next to the ham was a frozen roll of hamburger meat. The roll was cut in half and a loose piece of foil was</p>	F000371	<p><b>F371</b> <b>It is the practice of Willow Manor to assure that sanitary practices are in place related to food storage and preparation.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b> No specific residents were identified. The areas identified in the 2567 have been corrected as follows: The ham and hamburger meat in the walk-in freezer was disposed of. The bowels of salad in the reach-in refrigerator were disposed of. The pizzas and green peppers identified in the reach in freezer were disposed of. The ham and metal mixing bowl with potatoes has been disposed of. The ice machine in the area off of kitchen has been thoroughly cleaned</p> <p><b><i>Other residents that have the potential to be affected have</i></b></p>	04/11/2013			

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	<p>covering the end of the roll exposing the meat to the air. No date identifying when the meat had been opened was on the packaging. The (DSM) said, "It's hamburger someone opened and did not use it all and did not date it. It will need to be pitched."</p> <p>Observed in a reach-in refrigerator were 4 individual covered bowls of salad. The date documented on top of the lids was 3/1/13. The lettuce was observed to be brown. The DSM indicated the salads should be discarded. Also in the reach in refrigerator was a half full bag of lettuce with no documentation of the date the packaging was opened. DSM indicated she did not know when the bag of lettuce had been opened.</p> <p>On 3/4/13 at 10:45 A.M., the second kitchen toured prepared food for E,F,G,H and I Halls in the facility. Observed in the reach-in freezer was prebaked frozen pizza with the plastic wrapping pulled back, exposing the pizza to air. Located on the door of the reach-in freezer was a sleeve of personal, individual size pizzas. 2 pizzas were observed remaining in the sleeve. No documentation was noted on the</p>		<p><b>been identified by:</b> All residents could potentially be affected. Please refer below to systematic changes to prevent reoccurrence</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> All dietary staff has been in-serviced related to assuring that all food is dated in accordance with the regulations. The in-service also included assuring that the refrigerators and freezers and checked each day and any items identified be disposed of properly in accordance with the facility policy. The Dietary Manager is responsible for assure that food items are stored and disposed of properly. Maintenance has increased the frequency of the cleaning of the ice machine and the increased frequency has been added to the scheduled cleaning.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews storage of food and cleanliness of the ice machine. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and</p>				

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	<p>packaging indicating when the package had been opened. On a shelf on the door was an open bag of frozen green peppers which was half full. The bag of frozen green peppers had no date documenting when the package had been opened.</p> <p>Observed on the top shelf of the reach-in refrigerator was a metal mixing bowl covered with aluminum foil. The date "2/28/13" and the words "leached potatoes" were written on the foil. The Assistant Dietary Manager (ADM) indicated that leached potatoes had been prepared for a resident. The ADM indicated that the method of food preparation for the potatoes was to soak the potatoes in water before being used the next day. Located on the bottom shelf was a ham dated 2/26/13. The ADM indicated that the facility's policy was to throw meat away 5 days after being opened.</p> <p>An ice machine located in a small room off the kitchen hall had a brown, gel like substance on the plastic ice guard inside the cabinet. The substance was removable with a paper towel, yet it had not been cleaned off the plastic ice guard.</p> <p>During an interview with the</p>		<p>then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>		

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	<p>maintenance supervisor (MS) on 3/12/13 at 12:40 P.M., the MS indicated that he cleaned the ice machines once a month. The MS indicated that the ice machines might need to be cleaned every 3 weeks to prevent the gel like substance build-up from occurring. The MS said, "The water is bad around here."</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure resident bathrooms and bedrooms, 1 of 2 kitchen /pantry areas, and the laundry room were maintained in a functional and clean condition for 7 of 7 survey days.</p> <p>Room #32, #37, #35, #34, #29, #6, #35B, #29</p> <p>Findings include:</p> <p>During initial tour of the facility on 3/4/13 at 10:30 A.M., the following areas were observed:</p> <p>1. Room 32: One of the two knobs/handles of the closet door was missing; the right closet door had a 2 inch gash near the base of the door, exposing the hollow interior; the right side closet door also was observed to have two horizontal strips of dried glue type material which were two inches tall and extended the width of the closet door; the wall to the right of the resident's bed (by the window) had two areas, (each 1 foot tall and 10 inches wide), with the top layer of tan wall missing, exposing the white</p>	F000465	<p><b>F465</b></p> <p><b>It is the practice of Willow Manor to assure that the environment is safe, functional, sanitary, and comfortable for out residents.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>No specific residents were identified. The specific areas identified in the 2567 have been corrected in rooms # 32, 37, 35, 34, 29, 6, 35B, and 29.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>Potentially all residents could be affected. Please see below for systematic changes to prevent reoccurrence.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>The maintenance department has been in-serviced related to following of the preventive maintenance schedule. This assures that rooms are checked on a routine basis for needed</p>	04/11/2013
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	<p>drywall beneath; the wall to the left of the bed (located by the door), was observed to have scattered areas of tan paint missing exposing the white drywall beneath as well as a 2 inch gash through the drywall. When the light in the bathroom was turned on, the ventilation fan also came on which produced a loud, rattley, constant noise.</p> <p>2. Room 37: One of the two knobs/handles of the closet door was missing; the lower half of both closet doors was observed with scattered white/black mars and scratches throughout; in the bathroom were 4 non skid adhesive strips on the floor in front of the toilet. The strip closest to the toilet had 3/4 of the strip worn away, the second and third strips (away from the toilet) were observed to have the 2/3's of the center of the strip worn away; to the left of the toilet, was an area of white peeling paint, which exposed the tan surface beneath; unpainted, white spackling to the wall area left of the toilet and also the area between the mirror and top of the sink; brown residue was observed in the jagged, gapping edges of the caulking across the top of the sink; the grab bar across the wall from the toilet had been replaced with a shorter bar, with the four</p>		<p>maintenance attention so that they can be addressed. Housekeeping staff has been in-serviced related to assuring that cleaning schedules are followed and that they alert maintenance of any areas that may need repair as they are in the rooms daily. All staff has been in-serviced related to filling out communication forms if areas that require maintenance or housekeeping repairs are needed.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that randomly reviews 5 resident rooms for housekeeping/maintenance issues. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b> April 11, 2013</p>		

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	<p>anchor holes from the longer bar exposed and unfilled. When the light in the bathroom was turned on, the ventilation fan also came on which produced a loud, rattle, constant noise.</p> <p>3. Room 35: In the bathroom were two unpainted spackled areas to the wall, 2 inches x 3 inches in size; unfilled holes in the wall where the grab bar had been replaced with a smaller bar; wall by the base of the toilet with cracked/crumbled areas, exposing the drywall beneath. The vent slats in the fan, located in the ceiling, was visibly laden with dust.</p> <p>4. Room 34: The left knob/handle was missing to the closet doors; in the bathroom, the wall left of the toilet was observed to have peeling paint near the base of the wall, exposing the drywall beneath; juncture of the ceiling and wall behind the sink, was observed to have the center 2/3 of the juncture with unpainted spackling slathered on.</p> <p>5. Room 29: The caulking on the top of the sink, was observed to be jagged and gaping out 1/3 inch from the wall, exposing the drywall beneath. The caulking had brown/black residue in various areas</p>			

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	<p>throughout. The jagged/gaping caulking extended 3/4 the width of the sink.</p> <p>On 3/12/13 at 1:30 P.M., the Housekeeping Supervisor (HS) was interviewed. She indicated resident rooms are deep cleaned, once a month. She indicated when a staff member finds something that need to be repaired/taken care of, they have work orders they fill out. She indicated anybody can write a work order, including but not limited to, CNAs (certified nursing assistants) or Housekeeping staff. The HS indicated every resident room is cleaned every day.</p> <p>On 3/12/13 at 2:13 P.M., the HS provided a copy of a "Housekeeping In-Service" which was dated 1/1/2000. The HS indicated this is what her staff does for the "5-step daily patient room cleaning." The form included but was not limited to the following: "...spot clean walls: vertical surfaces are not completely wiped down daily - but must be spot-cleaned daily...The entire floor must be dust mopped - especially behind dressers and beds...All corners and along baseboards must be dust mopped..." At that time, she also provided a copy of the "Housekeeping Inservice, 7</p>						

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	<p><b>Step Daily Washroom Cleaning." The form was dated 1/1/2000 and included, but was not limited to, the following: "...Purpose: To show Housekeeping employees the proper method to sanitize a washroom or bathroom in a long-term care facility...Dust Mop Floor...Be sure to move any items in bathroom...Clean...sink...The sink includes: the sink, fixtures...mirror and light above the mirror...The top light cover...are the most difficult areas to get..do not forget them..."</b></p> <p>On 3/12/13 at 2:15 P.M., the Administrator was made aware of the above environmental areas. She indicated the facility has an "Interdisciplinary Communication form" (ICF) which is used to communicated between departments. The form directs to place the original in the designated departments box and carbon copy in the Administrators box to be followed up on. At that time, the Administrator provided a copy of the ICF which indicated room #34 was to have had the walls touched up. The form was dated and signed as completed on 1/15/13 by the maintenance department. The Administrator indicated the areas in room 34 were a repeat problem.</p>			

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	<p>6. On 3/12/13 at 9:16 A.M., the laundry room was toured with maintenance staff #1 . Behind the washing machines where the water pipes were attached to the wall surface the outer wall surface (masonite as described by maintenance staff) had eroded. The erosion damage had a large amount of brown discoloration and staining, exposing the the dry wall surface in large areas. The wall surface had missing and/ or peeling and discoloration for approximately 12 x 36 inches in that area. Maintenance staff #1 indicated the damaged wall was from water leakage. Another section of the laundry wall located where the washer machines had chemical dispensers attached to the wall had approximately a 44 foot section of the masonite surface eroding exposing the dry wall surface in large areas and/ or brown stainage.</p> <p>7. On 3/12/13 at 10:09 A.M., the kitchen/pantry area of unit A was toured. The cabinet area had a knob missing from one of the drawers. The middle drawer in the cabinet area would not close properly on the its track. The top drawer of the cabinet area had paint missing from one corner. The 2 department sink in the</p>						

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	<p>cabinet area had corroded areas on the bases and on the 2 drain areas. The microwave had a yellow substance inside on the top and base of the microwave. On 3/12/13 at 10:09 A.M., LPN # 4 was made aware of the above concerns. She indicated maintenance staff had been made aware of drawer not closing properly and were suppose to fix the drawer. She also indicated the yellow substance in the microwave had probably been from popcorn being made. On 3/12/13 at 3:55 P.M. the administrator was made aware of the kitchen/pantry problems on unit A. She indicated she did not know if there was a cleaning schedule for this area. She indicated it should be cleaned daily by housekeeping.</p> <p>8. On 3/12/13 at 10:15 A.M., the bathroom of room 6, was observed to have orange staining around the caulking at the base of the commode. The wall behind the commode had an approximated 2 x 2 inch hole.</p> <p>9. On 3/12/13 at 11:10 A.M., the bathroom of room 35 B was observed to have black soil around the base of the commode. The floor tiles surrounding the base of the commode had seams which contained black soil.</p>			

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