

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER ST CHARLES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN 47546
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 12, 13, 14, 17,18,19, 2014</p> <p>Facility number: 002628 Provider number: 155674 AIM number: 200299110</p> <p>Survey team: Amy Wininger, RN, TC Dorothy Watts, RN (11/12,13,14,18,19, 2014) Terri Walters, RN</p> <p>Census bed type: SNF: 15 SNF/NF: 38 Residential: 27 Total: 80</p> <p>Census payor type: Medicare: 14 Medicaid: 30 Other: 9 Total: 53</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect State findings cited in accordance with 410</p>	F000000	<p>St. Charles Health Campus has submitted the plan of correction and is asking for paper compliance as all areas noted in 2567 have been rectified and are in accordance to State and Federal Guidelines.</p> <p>The submission of this plan of correction does not indicate an admission by St. Charles health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of St. Charles Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.</p> <p>The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000282 SS=D	<p>IAC 16.2-3.1</p> <p>Quality review completed on November 25, 2014 by Jodi Meyer, RN</p> <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 ensure medications were administered according to the plan of care, in that, a transdermal patch application site was not rotated and/or applied as directed by the manufacturer for 1 of 1 residents reviewed for transdermal medications. (Resident #55)</p> <p>Findings include:</p> <p>During an interview with LPN #10 on 11/19/14 at 9:29 A.M., LPN #10 indicated the Medication Administration Record (MAR) documented the placement locations for the Exelon (a medication used to treat mild to moderate dementia) transdermal patches that had been placed on Resident #55. LPN #10 further indicated that, whenever an old transdermal patch was removed, the new transdermal patch would be placed on the</p>	F000282	<p>F 282</p> <p>Resident # 55 suffered no ill effect from alleged deficient practice and medication transdermal patch rotation form has been implemented. Completion Date 12-19-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in-servicing will ensure services provided by the campus are executed by qualified persons in accordance with each resident's written plan of care. An audit has been completed to assure all residents with Exelon patches have a transdermal patch rotation form. Completion Date 12-19-2014</p> <p>Nursing staff in-serviced on use of transdermal patch rotation form for Exelon patches Completion Date 12-19-2014</p> <p>Systemic change Staff will use a</p>	12/19/2014			

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	<p>opposite side of the body.</p> <p>The clinical record of Resident #55 was reviewed on 11/19/14 at 9:42 A.M. The record indicated the diagnoses of Resident #55 included, but were not limited to, the following: Alzheimer's with dementia.</p> <p>The most recent Quarterly MDS (Minimum Data Set) Assessment dated 10/18/14 indicated Resident #55 had mild cognitive impairment.</p> <p>On 11/19/14 at 12:15 P.M., Resident #55 was observed sitting at the dining table.</p> <p>The November 2014 Physician's Order read as follows: "Exelon 9.5 mg/24 hr patch. Apply 1 patch topically Q (every) 24 hours *Remove old patch*"</p> <p>The November 2014 Medication Administration Record (MAR) indicated the Exelon patch had been administered daily to Resident #55 from November 1st, 2014, through November 19, 2014. The MAR documentation indicated the transdermal patch had been placed on Resident #55's right shoulder, left shoulder, right back and left back.</p> <p>The Nurse's Drug Handbook 2014 edition, page 382, indicated:</p>		<p>transdermal patch rotation form when ever Exelon patches are ordered.</p> <p>Completion Date 12-19-2014</p> <p>DHS/designee to audit three random residents to assure transdermal patch rotation form is complete 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments.</p>				

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F000315 SS=D	<p>"Exelon...Patient Counseling:...do not apply new patch to same spot for at least 14 days..."</p> <p>During an interview with the DON on 11/19/14 at 11:15 P.M., the DON indicated that she would consult with the pharmacist about issues of Exelon patch placement and rotation. The DON indicated that a transdermal patch rotation form provided by the pharmacy would be used to track the locations of the patch placement daily.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a toileting program had been provided for a resident who had a decline in urinary continence for 1 of 2 residents who met the criteria for review of urinary</p>	F000315	<p>F 315</p> <p>Resident # 2 did not suffer ill effects for alleged deficient practice. His toileting plan has been reviewed and care plan updated.</p> <p>Completion Date 12-19-2014</p>	12/19/2014			

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	<p>incontinence in stage 2. (Resident #2)</p> <p>Findings include:</p> <p>On 11/14/14 at 9:30 A.M., Resident #2 was observed sitting in his recliner in his room.</p> <p>On 11/13/14 at 8:38 A.M., Resident #2's clinical record was reviewed. Resident #2 had been admitted to the facility on 7/19/14. His diagnoses included but were not limited to, insulin dependent diabetes mellitus, diabetic neuropathy, cataracts, depression, and mental retardation.</p> <p>The Admission Minimum Data Set Assessment (MDS) dated 7/28/14, indicated an extensive assistance of 1 staff needed for transfers and toileting. The assessment indicated Resident #2 did not have a toileting program and was always continent of bladder. The most recent Quarterly MDS dated 10/14/14, indicated extensive assistance of 2 staff needed for transfers, frequent urinary incontinence, and was not on a toileting program.</p> <p>A facility admission form entitled, "Elimination records/Schedule" was reviewed on 11/14/14 at 10:00 A.M. The documentation indicated Resident #2 had been monitored for urinary continence</p>		<p>All residents have the potential to be affected by the alleged deficient practice and therefore through corrective actions and in-servicing the campus will ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much bladder function as normal for each individual resident. All residents who are incontinent have been review2ed to assure appropriate toileting plan is in place.</p> <p>Completion Date 12-19-2014</p> <p>Nursing staff have been in-serviced on utilization of the elimination circumstance form. Care plans have been revised and updated as individual needs indicate.</p> <p>Completion Date 12-19-2014</p> <p>Systemic change is implementation of the elimination circumstance form when a resident has a change of continence status.</p> <p>Completion Date 12-19-2014</p> <p>DHS and/or designee will monitor 3 random incontinent resident to assure the most effective toileting plan is implemented 5x a week x one month then 3x a week x one month then weekly thereafter with results forwarded to the QA committee for 6 months and quarterly thereafter for further review and</p>				

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	<p>and had been continent of urine from 7/19/14 at 1:00 P.M., through 7/22/14 at 3:00 A.M. when monitoring had been discontinued.</p> <p>A CNA assignment sheet received and reviewed on 11/12/14, indicated Resident #2 was incontinent of urine and was not on a scheduled toileting program.</p> <p>The resident's current care plan entitled, "Individual Plan Report" addressed bowel and bladder with a date of 10/16/14. "... 10/16/14 I am at risk for constipation related to my decreased mobility and my medications. Observe me for and record my bowel movements every shift. Encourage me to consume at least 75% of my foods and fluids with each meal and snack. Offer me fluids between meals. Administer my bowel medications as ordered-see my current orders. If I have no bowel movement in 3 days, initiate bowel care. If, after you have exhausted all interventions, I still have not have a bowel movement, notify the doctor. My goal is to pass a soft formed stool every 3-4 days. Please review my interventions within 90 days to determine if any changes are needed." The current care plan had</p>		<p>suggestions/recommendations. Completion Date 12-19-2014</p>		

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F000323 SS=D	<p>addressed bowel status and did not address urinary status or incontinence.</p> <p>On 11/18/14 at 9:04 A.M., the Director of Nursing (DON) was interviewed in regard to Resident #2's toileting needs and review of the CNA assignment sheet and care plan in regard to urinary status. The DON was made aware of a decline in the resident's urinary continence from always continent (MDS 7/28/14) to frequently incontinent (MDS 10/14/14). The DON was also made aware of a lack of a scheduled toileting program to address Resident #2's urinary incontinence. The DON at that time indicated Resident #2 was frequently incontinent of urine without a scheduled toileting plan. The DON also indicated at that time that a toileting program was needed for Resident #2.</p> <p>3.1-41(a)(2)</p> <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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F000323	F 323 Resident #2 and #29 did not suffer ill	12/19/2014			

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	<p>adequate safety interventions were implemented and/or adequate supervision was provided, in that, interventions were not routinely implemented and/or witnessed/unwitnessed falls continued for 2 of 3 residents who met the criteria for review of accidents. (Resident #2, Resident #29)</p> <p>Findings include:</p> <p>1. On 11/17/14 at 10:07 A.M., Resident #2 was observed in the hall sitting in his wheelchair.</p> <p>On 11/13/14 at 11:38 A.M., Resident #2's clinical record was reviewed. Resident #2 had been admitted to the facility on 7/19/14. Resident #2's admission nursing assessment dated 7/19/14, indicated a cognition of alert and oriented and "...confused @ x's (at times)..." The assessment included, but was not limited to, a safety plan that indicated, "... Impaired cognition related to: mental retardation..." "... Has disease or condition that predisposes to falls..." His diagnoses included, but were not limited to, insulin dependent diabetes mellitus, diabetic neuropathy, cataracts, depression, and mental retardation. The Admission Minimum Data Set Assessment (MDS) dated 7/28/14, indicated an extensive assistance of 1</p>		<p>effects from the alleged deficiency. Safety care plans have been updated as appropriate. Completion Date 12-19-2014</p> <p>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will 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. Reviewed residents at risk to assure care plan interventions are appropriate and in place. Completion Date 12-19-2014</p> <p>Nursing staff have been in serviced concerning C.N.A. assignment sheets that include fall interventions. Systemic change: C.N.A are to carry assignment sheets to review interventions as needed. Campus will review entire medical record post fall to assure intervention effective. Interdisciplinary approach has been taken to help assess and identify residents to prevent accidents and fall risks, initiate Physical and/or Occupational therapy services with changes of ADL's, and adjustments of care plans as individual needs change. Completion Date 12-19-2014</p> <p>DHS /designee will monitor 3 random resident at risk for falls to</p>				

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	<p>staff needed for transfers and toileting. The assessment indicated Resident #2 did not have a toileting program and was always continent of bladder. The most recent Quarterly MDS dated 10/14/14, indicated extensive assistance of 2 staff needed for transfers, frequent urinary incontinence, and was not on a toileting program. The cognition score of MDS 7/28/14 and MDS of 10/14/14 indicated a total score of 15 (cognition intact).</p> <p>Resident #2's current care plan addressed the problem of falls with an initiation date of 7/29/14. The care plan indicated the resident was at risk for falls related to physical functioning and the usage of an anti-depressant medication. Interventions included but were not limited to, provide and monitor the use of walker/cane, and wheelchair, lock brakes on chair before transfers, remind resident and enforce safety awareness, and educate and remind resident to ask for assistance before ambulation.</p> <p>On 11/18/14 at 8:38 A.M., the following falls in regard to Fall Circumstance Assessments, nursing notes, and fall care plan were reviewed with the Director of Nursing (DON).</p> <p>A Fall Circumstance Assessment dated 8/24/14, indicated Resident #2's first fall</p>		<p>assure safety interventions are in place and interventions are effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 12-19-2014</p>				

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	<p>had occurred on 8/24/14 at 6:45 A.M. The documentation indicated the fall had occurred when a CNA had transferred the resident from bed to his wheelchair using a gait belt. The intervention initiated, "Educating staff & res (resident) about keeping w/c (wheelchair) close to bed and he's not sitting before staff informs him to do so..." IDT (Interdisciplinary Team) review on 8/25/14, indicated, "... Transfer training c (with) therapy (staff training)..." The DON indicated at that time the wheelchair should have been closer to the bed for transfer of the resident. The DON also indicated the intervention had been staff training by therapy department.</p> <p>The second fall occurred on 8/30/14 at 3:30 P.M. The Fall Circumstance Assessment indicated the fall had occurred in the resident's room and was unwitnessed. Documentation indicated, "... Sleeping in chair slipped out of w/c..." The DON was made aware the assessment had indicated the wheelchair brakes had not been locked. The intervention initiated after the 8/30/14 fall was to transfer Resident #2 to a recliner after the meals.</p> <p>A Fall Circumstance Assessment dated 9/23/14, indicated a third fall had occurred on 9/23/14 at 4:29 P.M., in</p>			

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	<p>Resident #2's room. The assessment indicated "...Pt (patient) drowsy, tried to transfer self to w/c and slid out of recliner before staff could assist..." The intervention initiated was to "keep w/c (wheelchair) out of sight to avoid self transfers." The DON indicated at that time that a nurse had been doing medication pass and had observed the resident transferring self. She also indicated the resident was not to transfer without assistance.</p> <p>On 11/17/14 at 12:50 P.M., Resident #2 was in his room sitting in his recliner and his wheelchair was observed in the hall room doorway area in the resident's view.</p> <p>The fourth fall occurred on 9/30/14 at 9:30 A.M. The Fall Circumstance Assessment indicated an unwitnessed fall had occurred at the nurses' desk. The documentation indicated Resident #2 had been reaching for a snack on nurses' station. The intervention initiated was to use dicem on top and under wheelchair pad. The DON indicated at that time that Resident #2 had already been using dicem under his wheelchair pad and the dicem was added on top of the wheelchair cushion.</p> <p>Another fall (witnessed) occurred on 11/2/14 at 8:25 A.M. The Fall</p>			

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	<p>Circumstance Assessment indicated the location of the fall was by the facility television life screen in the hall area (between the resident halls and the main dining room). An abrasion injury had occurred. Documentation indicated, "... Res (resident) had just stopped in front of TV to read life screen..." "... Slipped from w/c to floor..."</p> <p>Intervention initiated to prevent fall was "...Staff will take to room when Res appears to be sleepy..." The DON indicated a nurse had witnessed the fall and had not been able to get to the resident to prevent the fall. She indicated the resident would have been propelling his self in wheelchair from the breakfast meal. The DON was made aware at that time that the assessment lacked documentation of the resident being sleepy.</p> <p>A nursing note dated 11/2/14 at 8:25 A.M., indicated, "... Res (resident) conversed c (with) this nurse & did not appear to be sleepy as he read a Birthday today from the screen, to this nurse. Once assessed Res had 2 abrasions on face. 1 to forehead measuring 5.5 cm long x 2 cm wide. The second abrasion was to the L (left) side of the face above his ear measuring 1.5 cm L (long) x 1.2 cm wide..."</p>			

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	<p>A Fall Circumstance Assessment dated 11/11/14, indicated a 6th fall (witnessed) had occurred in the main dining room at a facility church service. The assessment indicated the resident had an abrasion injury to his left forehead. New interventions listed on the assessment were for anti-tippers to his wheelchair and to tilt the wheelchair seat. The IDT review on 11/17/14 regarding the 11/11/14 fall, indicated that the root cause of the fall was, "...leaning forward in chair, hand on knees..."</p> <p>The 7th fall occurred on 11/13/14 at 4:50 P.M. The Fall Circumstance Assessment dated 11/13/14 indicated the resident was found on the floor in his bathroom during the activity of self transferring and toileting. The assessment documentation indicated the intervention initiated after the 11/13/14 fall was to not leave Resident #2 unattended in the bathroom. The DON indicated Resident #2 had needed assistance of staff to toilet. The DON explained that Resident #2 had been left in bathroom while a CNA went to answer a call light.</p> <p>On 11/19/14 at 10:45 A.M., the Director of Therapy was interviewed in regard to the intervention of staff education training for the 8/24/14 fall. She indicated, at that time, documentation</p>			

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	<p>was lacking in regard to staff and resident education training after the 8/24/14 fall. The Director of Therapy indicated Resident #2 had been in therapy at that time and she had reviewed the therapy documentation and documentation was lacking of staff training.</p> <p>On 11/19/14 at 12:10 P.M., the DON was made aware of the lack of adequate supervision and/or effective interventions in regard to Resident #2's falls. Falls had been witnessed and unwitnessed by staff and /or were in resident activity areas such as the nurses's station, hall areas, and church service area with lack of adequate staff monitoring or supervision being provided.</p> <p>2. During an interview on 11/12/14 at 3:03 P.M., the DON (Director of Nursing) indicated Resident #29 had experienced a left hip fracture at home and was re-admitted to the facility on 10/02/14.</p> <p>On 11/13/14 at 10:30 A.M. Resident #29 was observed sitting in a wheelchair. A chair alarm was observed, at that time, to be attached to the back of the wheelchair.</p> <p>The clinical record of Resident #29 was reviewed on 11/17/14 at 9:00 A.M. The record indicated the diagnoses of</p>			

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	<p>Resident #29 included, but were not limited to, left hip fracture, chronic renal failure, and cerebrovascular disease.</p> <p>The Admission Physician Orders dated 10/02/14 lacked any orders for safety interventions.</p> <p>The Admission MDS (Minimum Data Set) Assessment dated 10/09/14 indicated Resident #29 experienced cognitive impairment, required the extensive assistance of two staff for transfers, required human assistance with transfers related to unsteadiness, experienced impairment to one side of the lower body, and had a history of falls with injury.</p> <p>The Nursing Admission Assessment dated 10/02/14 indicated, "...has cognitive impairment that effects safety/judgement...has a history of falls, requires assistance to transfer...Has disease or condition that predisposes to falls...can remove safety devices independently...can remove safety devices or doesn't prevent from previous act..." with safety interventions that included, but were not limited to, "...Provide assistive device and ensure it is accessible, provide assistance for transfers and ambulation as needed..."</p> <p>Fall #1:</p>			

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	<p>A nursing note dated 10/04/14 at 1:15 A.M. indicated, "...Heard noise coming from (room number). Went to room et (and) found resident lying on floor by door. Resident had been sitting in chair by door. Had refused X's (times) 3 (three) to go to bed. Resident hit back of head on floor et received et abrasion to old hematomas... "</p> <p>A nursing note dated 10/04/14 at 6:00 A.M. indicated, "...intervention put in place is alarm to w/c (wheelchair)..."</p> <p>A Fall Circumstance dated 10/04/14 at 1:15 A.M., indicated Resident #29 experienced a fall at that time. The Circumstance further indicated Resident #29 experienced cognitive or memory impairment that effects safety and judgment (sic), and/or has difficulty understanding and following directions.</p> <p>A Care Plan for Falls dated 10/04/14 included, but was not limited to, "Remind resident and reinforce safety awareness: lock brakes on...chair...before transferring...bed/chair alarm at X's (times)..."</p> <p>Fall #2: A nursing note dated 10/27/14 at 10:50 A.M. indicated, "...Res (resident) found on floor...stated he was trying to use the</p>			

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	<p>bathroom. Alarm not sounding. Res has been seen turning alarm off. Wheelchair brakes not locked..."</p> <p>A Fall Circumstance dated 10/27/14 at 10:50 A.M. indicated Resident #29 experienced a fall and included a handwritten note, "...Alarms in place, not sounding..."</p> <p>The Policy and Procedure for Falls provided by the DON on 11/18/14 at 3:30 P.M. indicated, "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measure...identified risk factors should be evaluated for the contribution they may have to the resident's likelihood falling...care plan intervention should be implemented that address the resident's risk factors..."</p> <p>During an interview on 11/18/14 at 10:00 A.M., the DON indicated safety interventions were not implemented on admission because Resident #29 had refused safety interventions during a previous admission. The DON further indicated, at that time, the safety interventions should have been implemented to prevent further falls.</p> <p>3.1-45(a)(2)</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 ensure adequate nursing staff was available for timely call light responses and /or meal service on 3 of 3 nursing units, in that, lack of sufficient staff was verbalized during 2 of 3 confidential family interviews, 11 of 22 confidential resident interviews, documented in resident council meetings and observed during 2 random observations. (Resident #201, Resident #202, Resident #203, Resident #204, Resident #205, Resident #206,</p>	F000353	<p>F 353</p> <p>Resident's 201 - 211 suffered no ill effects fro the alleged deficiency Completion Date 12-19-2014</p> <p>All residents have the potential to be affected by the deficient practice and through alterations and in services the campus will 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>	12/19/2014			

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	<p>Resident #207, Resident #208, Resident #209, Resident #210, Resident #211) (Unit 100, Unit 200, and Unit 300)</p> <p>Findings include:</p> <p>During 11 of 22 confidential resident interviews on the 100 unit, 200 unit and 300 unit, residents indicated they frequently had to wait greater than 15 minutes for call lights to be answered and/or their meals delivered to their rooms. Residents further indicated their call lights were frequently turned off by staff, at which time the staff indicated they would return in a few minutes. However, the staff either did not return at all or returned much later than a few minutes.</p> <p>Their comments included:</p> <p>1. During a confidential interview on 11/12/14 at 11:12 A.M., Resident #201 indicated the facility was short on staff, especially lately. Resident #201 said, "I've wet on myself I've had to wait so long."</p> <p>2. During a confidential interview on 11/12/14 at 11:51 A.M., Resident #202 indicated it took longer than 30 minutes after ringing the call light to get someone in here. "I've timed it several times</p>		<p>Completion Date 12-19-2014</p> <p>An in service/ roundtable was held to discuss staffing and meeting resident needs and call lights. Completion Date 12-19-2014</p> <p>Systemic change is staffing will be reviewed for all shifts in interdisciplinary meeting to ensure equate staffing. Completion Date 12-19-2014</p> <p>ED/designee will meet with 3 resident's to assure needs being met 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments Completion Date 12-19-2014</p>				

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	<p>myself." "It has been worse here lately because we are short of help." Resident #202 further indicated the staff would turn the call light off, say they would be back, but would forget about us. Resident #202 further indicated the same scenario had occurred more than a few times.</p> <p>3. During a confidential interview on 11/12/14 at 3:15 P.M., Resident #203 indicated there was not enough staff. Resident #203 further indicated that many times other staff members stated someone didn't come in and that the facility was short staffed, which was the reason the staff took longer to answer the call light.</p> <p>4. During a confidential interview on 11/12/14 at 4:15 P.M., Resident #204 indicated that it was occasionally hard to get some help very early in the morning, sometimes taking as long as 20 minutes to half an hour. Resident #204 said, "Sometimes I've had bowel and urinary accidents while waiting on them. I usually don't have accidents."</p> <p>5. During a confidential interview on 11/13/14 at 8:37 A.M., Resident #205 indicated the facility needed more help. Resident #205 said, "I depend on them because I can't walk. They apologize</p>				

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	<p>saying, "I'm sorry I didn't answer the light sooner."</p> <p>6. During a confidential interview on 11/13/14 at 8:49 A.M., Resident #206 indicated it took 15 to 30 minutes to get help, especially around meal time, and on all 3 shifts. Resident #206 further indicated the last day or two he has had to wait 30 minutes.</p> <p>7. During a confidential interview on 11/13/14 at 8:49 A.M., Resident #207 indicated the facility was short staffed because it may take 30 minutes after pushing the call light for someone to respond. Resident #207 said, "I don't think they are neglecting us. They just can't get to us."</p> <p>8. During a confidential interview on 11/13/14 at 9:19 A.M., Resident #208 said, "I'm waiting right now. I'm waiting on the lift. I want to get into bed. This last week I have waited 30 minutes or longer."</p> <p>9. During a confidential interview on 11/13/14 at 10:34 A.M., Resident #209 indicated sometimes it took nearly an hour to get someone to help get to the bathroom.</p> <p>10. During a confidential interview on</p>						

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	<p>11/13/14 at 8:49 A.M., Resident #210 indicated in the mornings residents would wait a long time for breakfast because only one person was serving tables.</p> <p>11. During a confidential interview on 11/13/14 at 2:15 P.M., Resident #211 indicated there was not enough staff to help residents. Resident #211 said, "I have waited a long time for someone to come, especially at night."</p> <p>12. The following were interviews with family members:</p> <p>During a confidential interview with a family member on 11/13/14 at 9:30 A.M., the family member indicated there was not enough staff to meet the needs of the resident in a timely manner. The family member further indicated sometimes it may take over 30 minutes to get someone to answer the call light.</p> <p>During a confidential interview with a family member on 11/13/14 at 2:23 P.M., the family member indicated there was frequently not enough nursing staff to answer call lights promptly. The family member said, "This place needs help like most places. They need more CNAs"</p> <p>13. On 11/18/14 at 8:45 A.M., during a random observation of rooms 101 and</p>			

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	<p>113, the call light above the entry door to both rooms was observed to be on. Continuous observation was maintained until 9:08 A.M., at which time the call lights were observed to be answered.</p> <p>14. Resident Council Minutes documentation for the past 6 months were received and reviewed on 11/19/14 at 10:01 A.M. Resident Council Minutes dated 10/27/14, indicated, "... Nursing - The call light is being turned off and nursing staff will say, 'We'll be back'...."</p> <p>A Policy and Procedure titled "Guidelines for Answering Call Lights" was provided by the Assistant Director of Nursing and reviewed on 11/19/14 at 11:17 A.M. The Procedure read as follows, "...12. Provide the service the resident requested and turn off the call light...13. If the service is unable to be provided do not turn off the call light until the appropriate staff is available to assist..."</p> <p>On 11/19/14 at 11:17 A.M., the Director of Nursing (DON) was interviewed regarding facility nursing schedules and staffing. The DON indicated, at that time, staff had recently been in-serviced on answering call lights in regard to not turning off call lights until providing the nursing service requested.</p>				

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F000371 SS=F	<p>3.1-17(a)</p> <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</p> <p>Based on observation, interview, and record review, the facility failed to ensure cooling down temperatures were appropriate for potentially hazardous food in that turkey cooked the previous day did not have a temperature below 40 F for 1 of 2 days when turkey roasts had been cooked and were in the cooling down process. This had the potential to affect 52 of 53 residents who received meals at the facility.</p> <p>Findings include:</p> <p>On 11/12/14 at 9:13 A.M., the initial tour of the facility kitchen began with the Food Service Manager (FSM). The walk in refrigerator was toured and the temperature was noted at 39 degrees Fahrenheit (F). Three pans of cooked turkey roasts (a total of 6 turkey roasts) were observed covered with foil in metal</p>	F000371	<p>F371</p> <p>Residents did not suffered ill effects from alleged deficient practice. Turkeys in question we disposed of immediately. Completion Date 12-19-14</p> <p>All residents have the potential to be affected by the alleged practice and through alterations, processes, and in-servicing the campus will ensure food is prepared and distributed under sanitary conditions. Completion Date 12-19-14</p> <p>In service all dietary staff concerning proper cooling methods and logging temperatures during cooling process. Completion Date 12-19-14</p> <p>Systemic change: dietary team will facilitate cutting large roast in quarters to facilitate cooling process and document accordingly. Completion Date 12-19-14</p>	12/19/2014			

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	<p>pans on moveable shelving in the walk in refrigerator. The pans had been dated 11/11/14. The FSM indicated at that time the turkey had been prepared yesterday afternoon for the Thanksgiving dinner tomorrow evening for the residents and their families at the facility. The FSM during interview at that time indicated the cooling down temperature from the point of the turkey completely cooked needed to have a temperature of 75 degrees F. in 2 hours and then the temperature needed to be cooled down to 41 degrees F. in 2 more hours. She indicated the turkey roasts had been baked and then cooled down by an "ice bath." She indicated the Assistant Food Service Manager (AFSM) had completed the preparation of the turkey roasts yesterday afternoon, but she was unable to find his documentation of the cooling down process.</p> <p>On 11/12/14 at 9:37 A.M., the FSM was asked to check the temperatures of the 6 turkey roasts. The FSM checked the temperature of one of the turkey roasts on the bottom pan. The digital thermometer registered 41.5 degrees F. The FSM indicated the thermometer was approximately a week old but she would check the temperature with another thermometer. She retrieved a new thermometer and rechecked the turkey</p>		<p>DFS/Designee will audit cooling sheets when cooling a large roast for compliance as part of ongoing daily sanitation with results forwarded to monthly QA committee meeting for further suggestions and comments. Completion Date 12-19-14</p>				

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	<p>roast and it registered 41.3 F. The FSM indicated the turkey roast needed to be discarded due to not the appropriate cool down temperature. The FSM then checked the temperature of one of the turkey roasts on the second pan. The temperature measurement was 41.5 F. She then on 11/12/14 at 9:51 A.M., checked one of the turkey roasts on the third pan and the temperature measured 43.7 F. The FSM indicated all the turkey roasts would be discarded.</p> <p>On 11/12/14 at 9:55 A.M., the FSM indicated, the turkey roasts had been cooked yesterday afternoon. She indicated she had left the facility at 4:00 P.M., but the AFSM had not finished with the turkey preparation until 7:00 P.M. She indicated she could not say for sure that she would have checked the temperatures of the cooled down turkey roasts if she had not been asked to check the temperatures this morning. The walk-in door of the refrigerator, at that time, was observed to have posted the cool down temperatures of 140 degrees F. to 70 degrees F. in 2 hours and 70 degrees F. to 40 degrees F. in 4 more hours.</p> <p>On 11/12/14 at 10:10 A.M., the FSM provided the cooling down documentation of turkey roast dated</p>			

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F000425 SS=D	<p>11/11/14 with beginning temperature at 3:09 P.M., at 189 degrees F., 3:30 P.M., 150 degrees F., 4:00 P.M., 120 degrees F., 4:30 P.M., 85 degrees F., 5:00 P.M., 68 degrees F., 5:30 P.M., 65 degrees F., 6:00 P.M., 53.4 degrees F., 6:30 P.M., 43.2 degrees F., and 7:00 P.M., 40.2 degrees F.</p> <p>On 11/18/14 at 11:00 A.M., the FSM provided a facility policy entitled, "3-501.14 Cooling (undated)." The policy included but was not limited to, "1. (A) Cooked POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cooled : 1. (1) within 2 hours from 57 degrees C (135 degrees F) to 21 degrees C (70 degrees F); and 2. (2) Within a total of 6 hours from 57 degrees C (135 degrees F) to 5 degrees C (41 degrees F) or less..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed</p>						

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	<p>personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on interview and record review the facility failed to ensure pharmacy services were provided, in that, a midline IV access procedure was not performed for 1 of 6 residents who met the criteria for review of pharmacy services. (Resident # 5)</p> <p>Findings include:</p> <p>The clinical record of Resident #5 was reviewed on 11/17/14 at 11:26 A.M. The record indicated the diagnoses of Resident #5 included, but were not limited to, urinary tract infection.</p> <p>An untimed Physician's Telephone order dated 07/17/14 indicated an order for "...Cipro (an antibiotic) 400 mg (milligrams) IV (Intravenous) BID (twice) daily X (times) 7 (seven) days..."</p>	F000425	<p>F 431</p> <p>Resident # 29 no longer resides at this Health Facility. Completion Date 12-19-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice therefore through alterations will provide Pharmacy service to meet the needs of each resident. Completion Date 12-19-2014</p> <p>Nurses have been in-serviced on campus procedure utilization of on call pharmacy. Completion Date 12-19-2014</p> <p>Systemic change: if pharmacy services have not carried out IV services within 2 hours the campus shall contact Executive Director. Completion Date 12-19-2014</p>	12/19/2014

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	<p>A nurse's note dated 07/17/14 at 3:00 P.M. indicated, "N.O. (new order) to run NS (normal saline)...via SQ (subcutaneous) until (name of pharmacy) arrives to place midline..."</p> <p>A Physician's Telephone Order dated 07/17/14 at 5:20 P.M. indicated, "...Run NS (Normal Saline)...SQ...until (name of pharmacy) arrives to place midline..."</p> <p>An untimed nurse's note dated 07/18/14 indicated, "...spoke with (name of physician) nurse regarding missing dose of Cipro...(name of physician) stated wanted Rsd (resident) to be sent to (name of hospital) ER (emergency room)..."</p> <p>During an interview on 11/19/14 at 11:00 A.M. the DON (Director of Nursing) indicated a peripheral IV line could not be established due to Resident #5 experiencing dehydration. The DON further indicated, at that time, two doses of the antibiotic were not administered on 07/17/14 because midline IV access was not established by the pharmacy provider. The DON then indicated Resident #29 was transferred to the hospital emergency room for treatment.</p> <p>A Resident Transfer form dated 07/18/14 indicated Resident #29 was discharged to</p>		<p>DHS/Designee will review 5 random residents' that require pharmacy IV insertion interventions to assure timely medication administration. 5x a week x one month then 3x a week x one month then weekly thereafter with results to be forwarded to QA committee monthly for review for 6 months and quarterly thereafter to ensure on going compliance and further recommendations/suggestions. Completion Date 12-19-2014</p>	

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	<p>(name of hospital) ER with a diagnosis of septic (sic) (severe blood infection).</p> <p>An email from the facility pharmacy dated 11/17/14 at 3:23 P.M., provided by the DON on 11/18/14 at 4:00 P.M., indicated,</p> <p>"...Midline placement issue...07/17/14 at 4:03 P.M. ... was contacted by PR (Pharmacy Representative) #1 for line placement (Unsure if facility contacted PR #1 directly or if IV RPh (Pharmacist) was told to contact him. PR #1 was out of town and forwarded placement (order)... 07/17/14 11:38 P.M. Order to... place midline arrives at pharmacy...07/18/14 6 am (A.M.) was contacted by PR #1 inquiring why line was not placed last night. PR #1 was told that line placement was "on hold, pending nephrology approval..."</p> <p>A Vascular Access Services Agreement provided by the HFA (Health Facilities Administrator) on 11/18/14 at 11:18 A.M. indicated, "... (name of Company #2) and (name of Company #1) ...is in the business of providing...midline placement...will have RN's available for dispatch seven days a week during normal service hours..."</p> <p>A letter from Company #2 provided by the HFA on 11/18/14 at 11:19 A.M.</p>			

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F000431 SS=E	<p>indicated, "...(name of Company #2) strives for a maximum 4 hours response time..."</p> <p>During an interview on 11/17/14 at 3:00 P.M., the HFA indicated he was unable to provide documentation of pharmacy services, but pharmacy midline should have been placed as soon as possible.</p> <p>During an interview on 11/18/14 at 8:30 A.M., the DON indicated (name of Company #2) should have placed the midline on 11/17/14. The DON further indicated the usual person who provided IV access services was out of town and had contacted the back up person to provide the service, but no one showed up.</p> <p>3.1-25(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently</p>				

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	<p>accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' medications were stored and/or disposed in a safe in a timely manner, for 2 of 3 medication carts observed. (Resident #67, Resident #64, Medication cart 100, and Medication Cart 300)</p> <p>Findings Include:</p> <p>1. On 11/19/14 at 8:59 A.M., an observation of the 100 hall medication storage cart was completed with LPN #11.</p> <p>During the observation the following was</p>	F000431	<p>F 431</p> <p>Resident #64 & 67. Medications were disposed of appropriately. Completion Date 12-19-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice therefore through alterations and in-services the campus will assure medications are stored appropriately /or will be disposed of in a timely manner... All Medication carts and treatment carts were audited by DON/designee for proper storage. Audit included inspection for expired medications and proper labeling. Completion Date 12-19-2014</p>	12/19/2014			

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	<p>observed:</p> <p>Located in the top drawer of the medication cart were 5 pills in a plastic medication administration cup. The medication cup lacked any documentation as to whom the pills belonged. During an interview at that time, LPN #11 indicated Resident # 67 had refused his medications this morning and she placed the pills in the drawer while she answered a call from another resident. LPN #10 further indicated the pills should have been destroyed.</p> <p>Located in the second drawer of the medication cart was a bottle of ferrous sulfate. The cap of the medication bottle was off and 2 pills were spilled out of the container and loose in the drawer.</p> <p>2. On 11/19/14 at 9:14 A.M., an observation of the 300 hall medication storage cart was completed with LPN #10.</p> <p>During the observation the following was observed:</p> <p>Located in the bottom drawer of the medication storage cart were 2 one gallon plastic Ziploc bags with 11 bottles of the following medications belonging to Resident #64:</p>		<p>Nurses have been in-serviced on campus procedure for proper storage of medications. Campus will request P.C.A. pharmacy consultant to also independently audit medication carts. Completion Date 12-19-2014</p> <p>Systemic change: each medication cart/ treatment cart/ will be checked weekly assure in compliance with policy. Completion Date 12-19-2014</p> <p>DHS/Designee will review 3 random resident's medication to assure medications dated when opened and checked for expiration and medications disposed of 5x a week x one month then 3x a week x one month then weekly thereafter with results to be forwarded to QA committee monthly for review for 6 months and quarterly thereafter to ensure on going compliance and further recommendations/suggestions. Completion Date 12-19-2014</p>				

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	<p>51 tablets of Simvastatin (an anti-lipid medication) 80 mg, 53 tablets of Promethazine (an anti-nausea medication) 25 mg, 124 capsules of Omeprazole (an anti-acid medication) 20 mg, 60 tablets of Synthroid (a thyroid hormone) 88 mcg (micrograms), 314 tablets of Tylenol (a pain reliever) 325 mg, 23 tablets of Sertraline (an anti-depressant medication) 100 mg, 66 tablets of Omeprazole 20 mg, 59 tablets of Centrum Silver, 104 tablets of Aspirin (an analgesic medication) 81 mg, 86 tablets of Mytabs (an antacid medication).</p> <p>During an interview at that time, LPN #10 indicated Resident #64 was admitted to the facility on 09/03/14 and that his family brought the Ziploc bags of medications to the facility upon his admission. LPN #10 further indicated the facility should have returned and /or disposed of the medications at that time.</p> <p>The Policy and Procedure for Disposal of Medications provided by the ADON (Assistant Director of Nursing) on 11/19/14 at 10:38 A.M. lacked any documentation related to the destruction of medications brought from home.</p>						

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F000441 SS=E	<p>During an interview on 11/19/14 at 2:13 P.M., the Director of Nursing (DON) indicated that if a resident refuses medication, it should be destroyed.</p> <p>3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact</p>			

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	<p>for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interview and record review, the facility failed to ensure employees were screened/evaluated for infectious conditions upon employment for 8 of 10 employees reviewed. (RN #14, RN #15, CNA #16, CNA #17, RCA #18, Activity Assistant #19, Dietary Aide #20, Housekeeper #21)</p> <p>Findings include:</p> <p>The Employee Files were reviewed on 11/18/14 at 11:30 A.M., and the following was noted:</p> <ol style="list-style-type: none"> 1. RN #14: The Employee Health Exam completed on 05/05/14 lacked a health risk assessment statement. 2. RN #15: The Employee Health Exam completed on 11/03/14 lacked a health risk assessment statement. 3. CNA #16: The Employee Health Exam completed on 09/19/14 lacked a health risk assessment statement. 4. CNA #17: The Employee Health 	F000441	<p>F 441</p> <p>Residents did not have ill effects for alleged deficiency. Completion Date 12-19-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice therefore through alterations and in-services the campus will utilize new Physical evaluation form. Completion Date 12-19-2014</p> <p>Team leaders and all hiring managers have been in-services on our new form to have all new applicants screened prior to employment at St. Charles health campus. Completion Date 12-19-2014</p> <p>Systemic change: Medical Director or Health Care designee(s) will screen all active working employees or any new employee's to be in accordance with infection control and communicable disease regulations. Completion Date 12-19-2014</p> <p>HFA/Designee will review all new employee physicals 5x a week x one</p>	12/19/2014			

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	<p>Exam completed on 08/12/14 lacked a health risk assessment statement.</p> <p>5. RCA #18: The Employee Health Exam completed on 05/12/14 lacked a health risk assessment statement.</p> <p>6. Activity Assistant #19: The Employee Health Exam completed on 02/04/14 lacked a health risk assessment statement.</p> <p>7. Dietary Aide #20: The Employee Health Exam completed on 10/06/14 lacked a health risk assessment statement.</p> <p>8. Housekeeper #21: The Employee Health Exam completed on 03/06/14 lacked a health risk assessment statement.</p> <p>A policy and procedure for Health and Safety provided by the Director of Nursing on 11/19/14 at 11:20 A.M., was reviewed and read as follows, "...An immunization evaluation for infectious conditions, tuberculosis screening, and immunization and infectious disease history maybe required from each applicant for employment.</p> <p>During an interview on 11/19/14 11:20 A.M., the RN Consultant indicated the Employee Health Exam Form should have included a health risk statement.</p>		<p>month then 3x a week x one month then weekly thereafter with results to be forwarded to QA committee monthly for review for 6 months and quarterly thereafter to ensure on going compliance and further recommendations/suggestions. Completion Date 12-19-2014</p>		

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R000000	3.1-18(b)(1) The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	St. Charles Health Campus has submitted the plan of correction and is asking for paper compliance as all areas noted in 2567 have been rectified and are in accordance to State and Federal Guidelines. The submission of this plan of correction does not indicate an admission by St. Charles health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of St. Charles Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.		

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure Service Plans were signed by the resident, in that, Service plans were not signed by the resident and/or responsible party for 7 of 7 residents who met the criteria for</p>	R000217	<p>R 217</p> <p>Resident #9,24,10,6,21,4,and 28 have their service plans signed and dated. Completion Date 12-19-2014</p> <p>All residents have the potential to</p>	12/19/2014
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	<p>review of Service Plans (Resident #R9, Resident #R24, Resident #R10, Resident #R6, Resident #R21, Resident #R4, and Resident #R28).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The clinical record of Resident #R9 was reviewed on 11/19/14 at 2:15 P.M. The most recent Service Plan dated 11/17/14 lacked any documentation of the cognitive level of Resident #R9 and lacked the signature of the resident and/or responsible party. 2. The clinical record of Resident #R24 was reviewed on 11/19/14 at 2:30 P.M. The most recent Service Plan dated 10/17/14 indicated Resident #R24 experienced no cognitive impairment and lacked the signature of the resident. 3. The clinical record of Resident #R10 was reviewed on 11/19/14 at 2:50 P.M. The most recent Service Plan dated 10/16/14 indicated Resident #R10 experienced cognitive impairment and lacked the signature of the resident and/or responsible party. 4. The clinical record of Resident #R6 was reviewed on 11/19/14 at 3:00 P.M. The most recent Service Plan dated 10/15/14 indicated Resident #R6 		<p>be affected by the alleged deficient practice and through alterations in processes and in servicing the campus will ensure service plans are signed and dated by the resident and/or responsible party. Completion Date 12-19-2014</p> <p>All current residents on assisted living have had their service plans reviewed, signed, and dated by the resident and. /or responsible party. Completion Date 12-19-2014</p> <p>An in-service has been completed with licensed nurses concerning completing the assisted living service plan and the importance of having the resident and/or responsible party sign and date the service plan. The systemic change is service plans will be reviewed monthly by the assisted living unit manager/designee to assure the resident and/or responsible party have signed and dated the service plan. Completion Date 12-19-2014</p> <p>DHS/Designee will audit 2 random resident's service plans to ensure the service plan has been signed by the resident and/or responsible party and</p>				

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	<p>experienced no cognitive impairment and lacked the signature of the resident.</p> <p>5. The clinical record of Resident #R21 was reviewed on 11/19/14 at 3:05 P.M. The most recent Service Plan dated 10/17/14 indicated Resident #R21 experienced moderate cognitive impairment and lacked the signature of the resident and/or responsible party.</p> <p>6. The clinical record of Resident #R4 was reviewed on 11/19/14 at 3:10 P.M. The most recent Service Plan dated 09/02/14 indicated Resident #R4 experienced severe cognitive impairment and lacked the signature of the resident and/or responsible party.</p> <p>7. The clinical record of Resident #R28 was reviewed on 11/19/14 at 3:30 P.M. The most recent Service Plan dated 06/18/14 indicated Resident #R28 experienced no cognitive impairment and lacked the resident's signature.</p> <p>During an interview on 11/19/14 at 3:35 P.M., Unit Manager #5 indicated the Service Plans were not signed by the residents and/or responsible parties.</p> <p>The Policy and Procedure for "Guidelines for Evaluation and Service Plan" provided by the DON (Director of</p>		<p>dated 5x a week x one month 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion Date 12-19-2014</p>				

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R000356	<p>Nursing) on 11/19/14 at 4:11 P.M. indicated, "...the resident and/or responsible party should also review and sign the form..."</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.</p> <p>Based on interview and record review, the facility failed to ensure the emergency information file contained allergy information for 2 of 5 residents who met the criteria for review of emergency file information. (Resident #R 10, Resident #R 6)</p> <p>Findings include:</p>	R000356	<p>Resident #6 and 10 have had their emergency file updated to include allergies. Completion Date 12-19-2014</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing the campus will ensure a current emergency infromation</p>	12/19/2014			

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	<p>1. The clinical record of Resident #R 10 was reviewed on 11/19/14 at 2:50 P.M. The most recent Physician's Order Recap dated 11/05/14 indicated Resident #R 10 experienced medication allergies to Cipro (an antibiotic) and Darvocet N-100 (a pain medication). The emergency file lacked any documentation related to allergies.</p> <p>2.. The clinical record of Resident #R 6 was reviewed on 11/19/14 at 3:00 P.M. The most recent Physician's Order Recap dated 11/04/14 indicated Resident #R 6 experienced no known allergies. The emergency file lacked any documentation related to allergies.</p> <p>During an interview on 11/19/14 at 4:00 P.M., the DON indicated the emergency file should contain information related to allergies and further indicated, at that time, the emergency files of Resident #R 10 and Resident #R 6 lacked any documentation related to allergies.</p> <p>The Policy and Procedure for Emergency Information File provided by UM (Unit Manager) #5 on 11/19/14 at 4:15 P.M. indicated, "...The file should contain the following information...Listing of any known allergies..."</p>		<p>file is up to date. All residents emergency files have been reviewed to assure allergy accuracy. Completion Date 12-19-2014</p> <p>An in-service has been completed with licensed nurses concerning completing the assisted living emergency files and requirements. The systemic change is the emergency files will be reviewed monthly with LOC to assure accuracy. Completion Date 12-19-2014</p> <p>DHS/Designee will audit 2 random resident's emergency files to assure accuracy 5x a week x one month 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 12-19-2014</p>				