

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2012
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NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 15, 16, 17, 18, 19, 2012</p> <p>Facility number: 002662 Provider number: 155684 AIM number: 200315930</p> <p>Survey Team: Shauna Carlson, RN TC Brenda Meredith, RN Lora Swanson, RN Amber Bloss, Medical Surveyor</p> <p>Census bed type: SNF: 34 SNF/NF: 21 Total: 55</p> <p>Census payor type: 20 Medicare 14 Medicaid 21 Other 55 Total</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/24/12</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This Plan of Correction is being submitted to meet the requirements established by State and Federal law.</p>	

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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	Cathy Emswiller RN			

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F0225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F0225	All of the abuse allegations	11/23/2012			

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	<p>interview, the facility failed to report allegations of abuse immediately to the state department of health for 2 of 4 allegations of abuse (sexual) for 2 of 4 residents reviewed for abuse. (Residents #49 and #200)</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 4 of 4 sampled investigations of allegations. (sexual, verbal, and misappropriations of resident property) for 4 of 4 residents. (Residents #49, #200, #33, #51)</p> <p>Based on record review, the facility failed to follow their policy to protect residents from abuse during an investigation by not suspending staff involved in the allegation for 1 of 4 sampled investigations for abuse allegations. (Resident #200)</p> <p>Findings include:</p> <p>1) On 10/18/2012 at 11:00 AM, 4 sample investigations were reviewed. According to the investigations, Resident #49 reported an allegation of sexual abuse on 7/14/2012 at 5:45 PM but it was not reported to the state department of health until 7/15/2012 at approximately 6:30 PM.</p> <p>On 6/6/12 at 5:00 PM, Resident #200</p>		<p>referenced below were self reported by the provider, prior to this survey and all of the allegations were unsubstantiated. All allegations and proven incidents of abuse (Physical, Sexual, Verbal and/or mental) will be reported immediately to the Administrator of the facility and to other officials in accordance with Federal and State law through established procedures (including to the State survey and certification agency). To assure that other residents are not affected by this deficient practice, staff have been in-serviced for signs and symptoms of potential abuse with residents in addition to changes within the policy. Additionally, the Resident Council has been made aware of this deficiency. The policy has been revised to address rudeness and the possibility of staff suspension during an investigation. To prevent this from reoccurring, quarterly, the Quality Assurance Committee will review every allegation of abuse for accurately following the policy and the timeliness in reporting the allegation. Failure to follow the policy will be reported to the Senior Vice President of Operations, the Administrator's direct report. Failure to follow the plan of correction will result in disciplinary action, up to and including termination. The Administrator is</p>		

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	<p>reported an allegation of sexual abuse which was not reported until 6/7/12 which was confirmed by interview with Employee #7.</p> <p>During an interview on 10/18/12 at 1:52 PM, Employee #7 indicated he understood allegations should be reported "immediately" to the state department of health.</p> <p>2) On 10/18/2012 at 11:00 AM, 4 sample investigations of allegations were reviewed (sexual, verbal, and misappropriation of resident property) for Resident #49, #200, #33, #51. 3 of 4 investigations lacked inclusion of staff interviews.</p> <p>On 10/17/2012 at 2:40 PM, the facility policy on abuse prohibition was received. The policy section 2.7A.1.1c with an effective date 9/2000 with revisions 9/05 and 8/11 states that staff incidents which involve abuse, neglect, involuntary seclusion, or misappropriation of property must be investigated with (section 3.6) "the administrator and/or designee obtain interview statements from all persons involved....."</p> <p>On 10/18/2012 at 1:52 PM during an interview, Employee #7 indicated that he only took verbal statements and</p>		responsible to carry out the plan of correction.				

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	<p>reported on his own conclusions. No further direct interview documentation was provided.</p> <p>3) On 10/18/2012 at 11:00 AM, 4 sample investigations of allegations of abuse were reviewed (sexual, verbal, and misappropriation of property) for Residents #49, #200, #33, and #51. On 6/6/2012 at approximately 5:00 PM, Resident #200 reported an allegation of sexual assault by two female staff members the evening of 6/5/2012. The immediate actions taken in the report did not state any staff were suspended pending the investigation. Though the allegation was made on 6/6/2012 at 5:00 PM, staff involved were not interviewed until after 11:00 AM on 6/7/2012 and no suspensions were noted.</p> <p>On 10/17/2012 at 2:40 PM, the facility policy on abuse prohibition was received. The policy section 2.7A.1.1c with an effective date 9/2000 with revisions 9/05 and 8/11 states that staff incidents which involve abuse, neglect, involuntary seclusion, or misappropriation of property must be investigated with (section 3.1) "the staff member is suspended immediately without pay, pending investigation.</p>			

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	3.1-28(c) 3.1-28(d)				

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F0226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to have an abuse policy to indicate all allegations of abuse must be reported immediately to the Administrator and the State Department of Health for 4 of 4 allegations reviewed for allegations of abuse. (Resident #49, #200, #33, and #51)</p> <p>Findings include:</p> <p>Policy for Reportable Unusual Occurrences reviewed on 10/17/12 at 2:40 p.m., effective date 07/02 and revised on 08/09, indicated "it is the policy of this facility that each unusual occurrence be reported within 24 hours to the Indiana State Board of Health."</p> <p>Policy for Abuse - Reporting/Response of/to reviewed on 10/17/12 at 2:40 p.m., effective date 09/00 indicated "it shall be the policy of...to report to the appropriate authorities any incident of abuse....".</p>	F0226	<p>All of the abuse allegations referenced below were self reported by the provider, prior to this survey and all of the allegations were unsubstantiated. All allegations and proven incidents of abuse (Physical, Sexual, Verbal and/or mental) will be reported immediately to the Administrator of the facility and to other officials in accordance with Federal and State law through established procedures (including to the State survey and certification agency). To assure that other residents are not affected by this deficient practice, staff have been in-serviced for signs and symptoms of potential abuse with residents in addition to changes within the policy. Additionally, the Resident Council has been made aware of this deficiency. The policy has been revised to address rudeness and the possibility of staff suspension during an investigation. To prevent this from reoccurring, quarterly, the Quality Assurance Committee will review every allegation of abuse for accurately following the policy and the timeliness in reporting the allegation. Failure to follow the</p>	11/23/2012			

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	<p>On 10/18/2012 at 11:00 AM, 4 sample investigations were reviewed. According to the investigations, Resident #49 reported an allegation of sexual abuse on 7/14/2012 at 5:45 PM but it was not reported to the State Department of Health until 7/15/2012 at approximately 6:30 PM.</p> <p>On 6/6/12 at 5:00 PM, Resident #200 reported an allegation of sexual abuse which was not reported to the Indiana State Department of Health until 6/7/12 which was confirmed by interview with the Administrator (Employee #7).</p> <p>During an interview on 10/18/12 at 1:52 PM, the Administrator indicated the policies of procedures did not define or address verbal mistreatment or rudeness. The Administrator also indicated he understood allegations of abuse should be reported "immediately" to the Administrator and the State Department of Health. 3.1-28(a)</p>		<p>policy will be reported to the Senior Vice President of Operations, the Administrator's direct report. Failure to follow the plan of correction will result in disciplinary action, up to and including termination. The Administrator is responsible to carry out the plan of correction.</p>		

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F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure dignity during the dining service. This deficiency affected 15 of 45 residents who received meals in the independent and assisted dining rooms. (Resident #117, #98, and #42)</p> <p>Findings include:</p> <p>1. (a) On 10/15/12 at 12:15 p.m., it was observed in the independent dining room 4 resident's were seated at the same table, 3 were served lunch at 12:15 p.m. At 12:34 p.m. it was observed that Resident #117 had not yet been served. Resident #117 indicated that staff took everyone's order at the same time, they are eating and I haven't received mine yet. Meal was served to Resident #117 at 12:35 p.m.</p> <p>1. (b) On 10/15/12 at 12:00 p.m., observation of Resident # 98 as he was seated at his table at 12:00 p.m. Meal was served to Resident #98 at</p>	F0241	<p>Residents #117, #98 and #42 are being served their meals timely. To prevent all other residents from being affected by this deficient practice, staff will be in-services on the proper order to serve meals. Changes were made based up on meal observations and need changes. Residents are being served on a rotation that changes with each meal. Special efforts will be made to serve a residents who arrived later and their table mates have already been served. Systemically, to prevent reoccurrence, a Dietary Supervisor position will monitor a meal service ten times per week. Additional in-serving will be conducted as necessary. The results of the monitoring will be reviewed by the Quality Assurance Committee quarterly. Failure to comply with this plan of correction will result in disciplinary action, up to and including, termination. The Director of Culinary Services will be responsible to carry out the plan of correction.</p>	11/18/2012	

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	<p>12:47 p.m.</p> <p>1. (c) On 10/17/12 at 12:51 p.m., during an interview with resident # 98 and resident #42 both seated at the same table, both resident's indicated the only reason they were served on time was because you are here doing a survey, maybe if you were here everyday we wouldn't be served last every time. Resident #98 and resident #42 also indicated that they always come to the dining room at 12:00 p.m., but we are always served last. This has gone on for a long time.</p> <p>1. (d) On 10/18/12 at 11:10 a.m., during an interview with Employee #3 it was indicated that he currently has the dining room set up into sections. During the lunch service the dietary staff are to take orders and serve meals in a clockwise pattern. At the dinner service the staff are to take orders and serve meals in a counter clockwise pattern.</p> <p>2. On 10/15/12 from 12:00 p.m. to 12:45 p.m., during observation of assisted dining room, CNA #4 was observed seated at her designated table of 4 residents to assist them but was not engaged in conversation with any of the residents.</p>				

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	<p>On 10/15/12 from 12:28 p.m. to 12:45 p.m. during observation of assisted dining room, CNA #5 was observed seated at her designated table of 3 residents to assist them but was not engaged in conversation with any of the residents.</p> <p>On 10/17/12 during observation of lunch from 12:00 p.m. to 12:50 p.m., it was observed that CNA #4, CNA #5, and RN #6 were seated at tables to assist residents and were talking amongst themselves without engaging in conversation with 10 of the 12 residents in the dining room.</p> <p>3.1-3(t)</p>				

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F0256 SS=C	<p>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to provide adequate and comfortable lighting levels in all areas. This had the potential to affect 55 of 55 residents.</p> <p>Findings include:</p> <p>On 10/18/12 between 9:30 AM and 10:30 AM during the environmental tour with Employees #7 (Administrator), #8 and #10, the following were observed:</p> <p>A. The overhead light near the Unit 100 bathroom entrance was not working. B. An overhead canister light bulb was out above the 100 Unit nurses station. C. Between the center hall nurses station and dining area, 5 light bulbs were out. D. In the 300 unit hall, in the common area and above the nurses station, 6 of 7 overhead light bulbs were out. E. In the 200 unit common bathroom, the large overhead light was not working inside the entrance. F. In the 200 unit hallway, 5 out of 6 light bulbs were out around the</p>	F0256	<p>Bids will be received no later than November 2, 2012 to repair and install high efficiency, LED lighting. Work will begin no later than December 2, 2012. Work will be completed no later than December 18, 2012. To prevent reoccurrence, weekly environmental rounds will be conducted by the Director of Environmental Services to assure lighting is functioning appropriately. Systemically, these rounds will be monitored by the Physical Environment Quality Assurance Committee monthly. Failure to comply with the plan of correction will result in disciplinary action, up to and including termination. The Director of Environmental Services is responsible to implement the plan of correction.</p>	11/18/2012			

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	nurses station.  On 10/18/12 at 9:45 am, interview with Employee #8 indicated there were areas that lacked sufficient lighting for safety.  3.1-19(dd)				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan for 2 of 2 residents reviewed for hydration (Resident #45 and #114) of 40 sampled residents.</p> <p>Findings include:</p> <p>1) On 10/15/2012 at 2:58 PM, during an interview, Resident #45 indicated she did not receive the fluids she wanted between meals. No fluids were observed in her room nor offered during the interview.</p>	F0279	Residents #45 and #114 care plans have been up dated to reflect their current diagnoses and related problems. For all other residents that could be affected by this deficient practice, an audit has been conducted of all care plans to assure their accuracy. Systemically, to prevent reoccurrence, all care planning, inter-disciplinary team members will be in-serviced as to the content of the care plan related to all diagnoses and problems. The MDS Coordinator will randomly audit 10 residents' care plans per month. The results of this will be reported to the Quality Assurance	11/18/2012

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	<p>On 10/17/2012 at 10:07 AM clinical records were reviewed for Resident #45 which indicated a UTI care plan indicating fluids offered every shift with meals, meds, snacks, hydration cart and at bedside.</p> <p>A care plan dated 10/14/12 indicated that Resident #45 began Macrobid 100 mg for 10 days for UTI.</p> <p>A Psychiatric Medication Care Plan for Resident #45 for Remeron given for depression was reviewed which listed possible side effects listed as dry mouth, urinary retention...</p> <p>A long standing physician order for Fluid Restriction indicated a Fluid Restriction of 2500 mL due to CHF (congestive heart failure).</p> <p>On 10/17/2012 at 2:12 PM, an interview with Employee #6 and Employee #11 indicated that there was no care plan for Fluid Restriction. A care plan for Fluid Restriction was presented on 10/19/2012 at 10:40 AM dated 10/17/2012.</p> <p>2) On 10/15/12 at 10:58 a.m., interview with Resident #114 indicated he had complaints of dry mouth.</p>		<p>Committee quarterly. When a 100% compliance is reached for any three consecutive month period, routine monitoring will end. Failure to reach this threshold will cause the monitoring to continue and the Quality Assurance Committee to make recommendations on ways to improve the process. Failure to comply with the plan of correction will result in disciplinary action up to and including termination. The Director of Nursing is responsible to carry out the plan of correction.</p>				

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	<p>On 10/19/12 at 10:40 a.m., clinical record review indicated Nystatin oral solution was ordered four times daily for 10 days on 9/25/12. Nursing admission assessment 9/24/12 indicated mucous membranes were dry and pink.</p> <p>On 10/17/12 at 9:30 a.m., interview with RN # 6 indicated his anti thrush solution had not been care planned, but should have been.</p> <p>On 10/17/12 at 10:30 a.m., interview with Employee #11 (Director of Nursing) indicated Resident #114 did not get a care plan for his anti thrush swish because the physician did not give the resident a diagnosis of thrush when ordering the solution. Employee #11 also indicated a care plan would have assisted in follow up.</p> <p>3.1-37(a)</p>						

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure the highest level of functioning and well-being by failing to evaluate the results of an intervention for 1 of 2 residents reviewed for hydration out of 40 sampled residents. (Resident #114)</p> <p>Findings include:</p> <p>On 10/19/12 at 10:40 a.m., clinical record review of Resident #114 indicated Nystatin oral solution was ordered four times daily for 10 days on 9/25/12. Nursing admission assessment 9/24/12 indicated mucous membranes were dry and pink.</p> <p>On 10/17/12 at 9:30 a.m., interview with RN # 6 indicated his anti thrush solution had not been care planned but should have been and no further assessment had been given after the 10 days of the anti thrush solution were completed.</p>	F0309	Resident #114 has been re-assessed and a new order received to continue Nystatin oral solution. All other residents that could be affected by this deficient practice are being re-assessed to assure they are receiving services to attain or maintain their highest practical physical, mental and psychosocial well-being. Systemically, the inter-disciplinary care plan team is being in-serviced on assessing residents' needs prior to and when discontinuing an identified problem. The MDS Coordinator will randomly audit 10 residents' acute care plans per month for diagnosis appropriate care plan and assessment at completion of problem reflected in documentation. The results of this will be reported to the Quality Assurance Committee quarterly. When a 100% compliance is reached for any three consecutive month period, routine monitoring will end. Failure to reach this threshold will cause the monitoring to continue and the Quality Assurance Committee to make recommendations on ways	11/18/2012	

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	<p>On 10/17/12 at 10:30 a.m., interview with Employee #11 (Director of Nursing) indicated Resident #114 did not get a care plan for his anti thrush solution because the physician did not give the resident a diagnosis of thrush when ordering the solution. Employee #11 also indicated staff had not reassessed Resident #114's mouth.</p> <p>On 10/15/12 at 10:58 a.m., interview with Resident #114 indicated he had complaints of dry mouth.</p> <p>On 10/18/12 at 2:30 p.m., interview with Resident #114 indicated his mouth was still dry, he was still uncomfortable and he was having trouble sleeping due to this discomfort. Observation of resident showed his lips were sticking together.</p> <p>3.1-37(a)</p>		to improve the process. Failure to comply with the plan of correction will result in disciplinary action up to and including termination. The Director of Nursing is responsible to carry out the plan of correction.		

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F0323 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, the facility failed to properly secure potentially hazardous materials in the sanitation cabinets for 3 of 3 unit common bathrooms. This had the potential to affect all 57 residents.</p> <p>Findings include:</p> <p>During the environmental tour on 10/18/2012 between 9:30 AM and 10:30 AM with Employee #7, Employee #8, and Employee #10, the 100 unit and 300 unit common bathroom was observed with an unsecured lock on the sanitation closet. The 200 unit common bathroom was observed as having no lock on the sanitation closet.</p> <p>3.1-45(a)(1)</p>	F0323	<p>All of the sanitation cabinets noted have been and remain secured. All other hazardous areas during the tour were found to be secured and remain that way. To prevent this from reoccurring, all staff will be in-serviced as to the importance of securing any hazardous area. Systemically, licensed nursing staff will assure the cabinets are locked after each use and document this. Additionally, environmental rounds will be conducted weekly to assure compliance. Failure to comply with the plan of correction will result in disciplinary action up to and including termination. The Director of Environmental Services is responsible to carry out the plan of correction.</p>	11/18/2012

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F0334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>				

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to provide documentation of consent or refusal while administering the influenza vaccine to 1 of 5 residents reviewed for vaccines. (Resident #74).</p> <p>Findings include:</p> <p>On 10/19/12 on 9:40 a.m. during record review for Resident #74 there was not a current signed consent for the influenza vaccine for the 2012 season. Review of immunization record indicated Resident #74 had received the influenza vaccine on</p>	F0334	Written consent has been received from resident #74. To prevent this deficient practice from affecting other residents, an audit has been conducted of all residents who received an influenza vaccine to assure written consents were received. For the remainder of the is flu season, all new admissions' vaccine consents will be monitored by the Unit Managers. The audits will be reported to the Quality Assurance Committee quarterly. Nursing personnel will be in-serviced to the facility policy and the need to obtain written consents prior to administering the vaccination.	11/18/2012	

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	<p>10/3/12.</p> <p>Review of current facility policy for Influenza and Pneumococcal Vaccines, received on 10/15/12 at 11:00 a.m. from Administrator, indicated "It is the policy of this facility to obtain on admission informed consent for a resident to participate in the facility's immunization program and then to assure that appropriate immunization is given."</p> <p>On 10/19/12 at 9:52 a.m., interview with RN #9 indicated she believed they had gotten phone consent but it was not documented.</p> <p>3.1-13(a)</p>		<p>Systemically, the Nursing Unit Managers will assure the written consents have been received prior to the nurse administering the vaccination. Failure to comply with the plan of correction will result in disciplinary action, up to and including termination. The Director of Nursing is responsible to carry out the plan of correction.</p>		

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F0356 SS=C	<p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to post the facility name and the total hours of licensed and unlicensed nursing staff worked daily on the Daily Staffing Report for 5 of 5 days the</p>	F0356	The posting has been changed to include the facility name and the actual hours worked, number of staff by position and shift. The posting will be completed by the Nursing Scheduler to reflect the scheduled hours to be worked by	11/18/2012			

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	<p>posting was observed (10/15, 10/16, 10/17, 10/18, and 10/19/12)</p> <p>Finding includes:</p> <p>The "Daily Staffing Report" was observed and reviewed during the 5 days of survey, from 10/15/12 through 10/19/12. The posting indicated the total number of Registered Nurse's (RN's), Licensed Practical Nurse's (LPN's) and Certified Nurse Aides (C.N.A.'s). The posting did not include the actual hours worked by each direct care staff category. The posting did not include the name of the facility.</p> <p>During an interview on 10/18/12 at 2:50 P.M., employee #9 indicated she was instructed to make the form but was unsure of the requirements.</p> <p>3.1-13(a)</p>		<p>shift and position. The licensed nurse at the end of each shift will make any necessary corrections due to any schedule changes (Call offs, tardies, etc.). The Nursing Scheduler will monitor 5 days per week reconciling the poster with the payroll system. Failure to comply with the plan of correction will result in disciplinary action, up to and including termination. The Administrator is responsible to carry out the plan of correction.</p>		

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F0371 SS=C	<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 distribute and serve food under sanitary conditions in regard to not wearing beard protectors while preparing food. This deficiency affected 55 of 55 residents who receive meals in the facility.</p> <p>Findings include:</p> <p>On 10/17/12 at 12:10 p.m., it was observed Employee # 1 had a full beard and no beard protector in place. Employee #1 was preparing food on the grill.</p> <p>On 10/19/12 at 11:10 a.m., it was observed Employee # 2 had a partial beard and no beard protector in place. Employee # 2 was preparing food on the grill.</p> <p>On 10/19/12 10:50 a.m., during interview Employee # 3 indicated his understanding on use of beard protectors is if the beard is neat and</p>	F0371	Employee #1 has removed his neatly, trimmed beard. Employee #2 is now wearing a beard protector. To prevent this deficient practice from affecting other residents, staff have been in-serviced as to the importance of covering all facial hair with a beard protector. Systemically, the staff will be monitored daily by the Dietary Supervisory Staff to assure compliance. The results of their findings will be reported to the Quality Assurance Committee quarterly. Failure to comply with the plan of correction will result in disciplinary action, up to and including termination. The Director of Culinary Services is responsible to carry out the plan of correction.	11/18/2012	

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	trim protectors are not necessary. Facility had beard protectors available for use in the kitchen.  3.1-21(i)(3)				

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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 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 there was an accurate system for liquid narcotic reconciliation for 1</p>	F0431	The facility administered the liquid narcotic as prescribed by the attending physician. Per the manufacturer's packaging requirements mandated by the	11/18/2012			

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	<p>of 1 med carts observed.</p> <p>Findings include:</p> <p>On 10/19/12 at 9:10 a.m., Roxanol liquid pain medicine was observed in the 300 hall med cart. Dosage label on bottle indicated strength was 20 mg/mL, residents prescribed dose was 5 mg or 0.25 mL. The narcotic count log for resident indicated there was 27 mL' s' left in bottle. Observation of the Roxanol bottle showed there was more than 27 mL's left. Interview with RN #6 indicated that without looking at narcotic log sheet, she would estimate there was "28 mL's or so" left.</p> <p>Observation of new sealed bottle of Roxanol liquid pain medicine retrieved out of Narcotic EDK box in med cart showed there was 31 mL's in bottle. Interview with RN #6 indicated this is always how the bottled narcotic came from the pharmacy and this is how the manufacturer made it.</p> <p>Interview with RN #11 on 10/19/12 at 9:25 a.m. indicated when all doses were removed from bottle there was extra liquid in bottle from "overflow" and this was brought to DON for wasting.</p> <p>3.1-25(e)(2)</p>		<p>Food and Drug Administration (FDA) a 30 ml bottle should be filled between 31ml - 33mls. The manufacturer further states the graduation on the bottle should not be used to accurately measure the content. The manufacturer's internal, quality control procedures, sets a fill standard of 31.5 mls for each 30 ml vial. Systemically, when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the Medication Administration Record (MAR): First, date and time of administration. Second, amount administered. Third, signature of the nurse administering the dose, completed after the medication is actually administered. Any extra medication that remains in the vial will be accounted for (amount), documented and destroyed in accordance with the facility policy. If the remaining medication exceeds the manufacturer's fill range as established by the FDA, an audit of the accountability record will be conducted and the pharmacy notified of the results. The monitoring will continued indefinitely. Failure to follow the plan of correction will result in disciplinary action, up to and including termination. The Director of Nursing is responsible to carry out the plan of correction.</p>		

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	3.1-25(e)(3)				

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F0441 SS=B	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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 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. <b>Based on observation and interview, the facility failed to transport linens in</b></p>	F0441	The linens identified were removed from serviced, washed	11/18/2012			

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	<p>a manner to prevent contamination and the transmission of infection. This deficient practice potentially affected 55 of 55 residents in the facility.</p> <p>Findings include:</p> <p>On 10/15/12 at 12:13 PM, a covered clean linen cart was observed being transported through the hallway between the two dining rooms with blankets uncovered on the top of the cart.</p> <p>On 10/17/12 at 12:30 PM, a covered linen cart was observed delivering clean linens to residents in the 100 unit hall with blankets uncovered on top of the cart.</p> <p>On 10/18/12 at 9:30 AM, during the environmental tour, three clean linen carts were observed in the laundry room with blankets uncovered on the top. When interviewed, the Administrator (Employee #7) indicated the blankets should be covered during delivery of clean linen. Employee #8 indicated there was not enough room for the blankets inside the cart due to the containers used to divide resident clothes.</p>		<p>and delivered in an enclosed, covered container. For all other residents potential affected by this deficient practice, the Laundry Staff have been in-serviced on the proper collection, distribution and handling of clean linen. The Infection Control Committee will monitor clean linen distribution three times per week for 14 days. If a 100 percent compliance is achieved during this 14 day period, monitoring will be reduced to 1 time per week for the next 30 day period. If compliance continues at 100 percent, monitoring will be reduced to randomly, once per month. If at any time, 100 percent compliance is not achieved, the Laundry Staff will be re-serviced. Failure to comply with the plan of correction will result in disciplinary action, up to and including termination. The Director of Environmental Services is responsible to carry out the plan of correction.</p>		

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F9999	<p>3.1-20</p> <p>(e) The food service director must be one (1) of the following: (2) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year experience in some aspect of institutional food service management.</p> <p>This state regulation was not met indicated by the following:</p> <p>Based on interview and record review the facility failed to employ a licensed food service director or a student enrolled in a food service supervision course that would be completed within one year. This deficient practice had the potential to affect 55 of 55 residents.</p> <p>Findings include:</p> <p>On 10/19/12 at 11:06 a.m., review of the employee license and certifications book indicated neither</p>	F9999	<p>The Evening Dietary Supervisor has been, and is currently enrolled in a division approved, Food Service Director's course through the University of Florida. Documentation is available from the University of Florida that the remainder of the course may be completed in less than 12 months. To assure the dietary needs of the residents continue to be met, the Registered Dietician has been, and will continue visiting the facility two times the state required hours. Systemically, the Dietician will document as to the continued progress of the Evening Dietary Manager in the Food Service Director's course. Failure by the Dietary Evening Supervisor to progress on a monthly basis will result in termination and the community hiring an individual that meets the state qualifications for a Dietary Supervisor. The Director of Culinary Services is responsible to carry out the plan of correction.</p>	11/18/2012	

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	<p>Employee #3 (Dietary manager) or Employee #2 (Evening kitchen supervisor) held a license in food service management.</p> <p>On 10/19/12 at 11:30 a.m., interview with Administrator (Employee #7) indicated neither Employee #3 or Employee #2 held a license in food service management.</p> <p>On 10/19/12 at 11:50 a.m., interview with Administrator (Employee #7) indicated that Employee #2 was currently enrolled in the required food service management courses but would not be completed within a year.</p> <p>3.1-20(e)(2)</p>				