

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2016
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NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00200966.</p> <p>Complaint IN00200966 - Substantiated. No Federal/State deficiencies related to the allegations are cited.</p> <p>Survey dates: June 8, 9, 10, 13, 14, 15, 2016</p> <p>Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980</p> <p>Census by Bed Type: SNF/NF: 43 Total: 43</p> <p>Census by Payor Source: Medicare: 7 Medicaid: 28 Other: 8 Total: 43</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	F0000 Preparation and Implementation of this Plan of Correction does not constitute admission or agreement by the provider with the Statement of Deficiencies. This Plan of Correction is prepared and/or implemented in order to comply with State and Federal regulations.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0248 SS=D Bldg. 00	<p>QR completed on June 20, 2016 by 17934.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was provided opportunities for activities, which were identified on the activity assessment as preferences for activity pursuits. The facility further failed to ensure a resident who consistently refused group activities was provided 1:1 activity programming for 1 of 4 residents reviewed for activities. Resident #41</p> <p>Findings include:</p> <p>On 6/10/16 at 10:00 a.m., the clinical record of Resident #41 was reviewed. Diagnoses included, but were not limited to, the following: Anoxic Brain Damage, Drug Overdose and Quadriplegia. The MDS (Minimum Data Set) assessment</p>	F 0248	<p>F248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT</p> <p>i. <u>What corrective action(s) will be accomplished for those residents found to be affected by the Deficient practice:</u></p> <p>1. Activity assessment was completed for resident #41 on June 14th, 2016 by the director of activities.</p> <p>2. The Plan of Care for resident #41 was updated on June 14th, 2016 to reflect the following changes on resident #41's activity plan of care.</p> <p>Activities added for Resident include:</p> <ol style="list-style-type: none"> 1. Movies 2. Music, resident has phone and CDs and CD player 	07/15/2016

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	<p>dated 4/5/16, included but was not limited to, the following: total cognitive score of 07, which indicated moderately impaired cognition.</p> <p>An Initial Activities Evaluation was dated 7/15/15 and included, but was not limited to, the following: Current interest in music and sports. A comment included the following: "Due to diagnosis of Anoxic Brain Damage and Drug Overdose per medical history (resident name) is unable to communicate his likes and dislikes. With family input he likes rap music and sports but nothing specific."</p> <p>A care plan, with a goal date of July 2016 addressed the following issue "...able to communicate needs, likes et (and) dislikes for activities. Goals: will accept stimulation from music and TV sports programs on a one on one basis x 2 per week through next review period. The care plan had an original date of 7/15/15. Approaches included the following: "staff will put music on CD player for (resident name) to hear; staff will turn TV on to sport channel when applicable." The goal date was documented as 7/2016.</p> <p>On 6/10/16 at 2:00 p.m., 6/13/16 at 3:00 p.m., 6/14/16 at 2:00 p.m., the resident's room was observed. There was no</p>		<p>3. Sports shows as available per TV schedule.</p> <p>C. CD player is in resident room and available for use.</p> <p>D. Activity Director has implemented 1:1 activities with resident #41.</p> <p>II. <u>How are other residents having the potential to be affected by the same deficient practice and What corrective actions will be taken:</u></p> <p>1. A review of all residents' Activity Assessments will be performed by the director of activities to ensure each resident has:</p> <p>1. A current Activity Assessment 2. Activities listed for each resident that reflect their current interests/likes 3. Activity Participation Logs for each resident. The activity staff will be responsible for documenting activity participation and/or refusals.</p> <p>1. For any resident who does not have a current Activity Assessment, current activities of interest, or an Activity Participation Log, one will be completed by the director of activities.</p> <p>III. <u>What measures will be put into place or what systemic changes will be made to ensure that</u></p>	

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	<p>observed CD player in the resident's room at this time.</p> <p>On 6/13/16 at 2:50 p.m., the Activities Director was interviewed. He indicated he encouraged Resident #41 to go to activities daily, but the resident refused. The Activity Director indicated he had thought about putting the resident on 1 to 1 activity programming since the resident had refused group activities but as of now had not done so. The Activity Director indicated the resident indicated he did not want to be part of a group. At this time, the Activity Director provided the resident's activity participation logs for May 2016 and June 2016. Both of the monthly logs were blank and lacked documentation of refusal of activities. At this time, the Activity Director indicated he had not documented the resident's refusals to attend activities on the Activity Participation logs.</p> <p>On 6/15/16 at 10:00 a.m., the Activity Director provided a copy of the current activity Calendar. The group calendar for June 2016 did not include activities of the resident's interest of rap music or sports. The activities listed on the group calendar for June 2016 were not identified as areas of interest for Resident #41.</p> <p>On 6/14/16 at 11:14 a.m., the</p>		<p><u>the deficient practice does not recur:</u></p> <p>1. The activity staff will receive re-education from the Administrator regarding the policy and procedure for Activity Assessments and documentation on the Activity Participation Logs.</p> <p>2. When a resident experiences a significant change (according to MDS guidelines) the Activity Director will review current Activity Assessment (during the assessment reference period) with resident to ensure that resident's documented activity preferences are still appropriate. A new Activity Assessment will be performed at this time and the residents' plan of care will be revised by the activity director.</p> <p>IV. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place:</u></p> <p>1. The Executive Director, or his designee, will perform audits of Activity Assessments. Five resident charts will be reviewed to ensure residents have current Activity Assessments and completed Activity Participation Logs. These will be performed once a week x 4 weeks, then Biweekly x 8 weeks, then monthly for 3 months.</p>	

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	<p>Administrator provided a current copy of the facility policy and procedure for "Participation in Activities", dated 11/30/14. The policy and procedure included, but was not limited to, the following: "...A daily record of resident activity involvement both independently and in group settings will be maintained in the Director of Therapeutic Recreational Services' office...Residents are encouraged to attend and participate in activities of their choosing...The facility, to the extent possible, will accommodate an individual's needs...A record of the resident's involvement will be maintained in the Director of Therapeutic Recreational Services' office. The form should be completed as follows: Daily activity record form is set up for each month...utilize the participation key to describe the residents degree of participation in the activity..." The Activity Director indicated when the resident initially came to the facility July 2015, the resident was unable to communicate. The Activity Director indicated that currently, the resident was able to communicate and make his wants and needs known. The Activity Director indicated the resident's activity assessment had not been updated with the resident's improved condition to assess his activity preferences.</p>		<p>2. Anyarea/trend of non-compliance will be reported to QAPI Committee for review and recommendations, up to and including extending the auditing time frame.</p> <p>V. <u>By what date will the systemic changes be completed?</u> A. July 15, 2016</p>	

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F 0279 SS=D Bldg. 00	<p>On 6/16/16 at 1:00 p.m., the Regional Director of Clinical Services #1 was interviewed. She indicated the Activity Director had just provided the resident with a CD player and CDs which were consistent with the resident's music preferences. She also indicated the Activity Director was also working with the resident to update his activity preferences.</p> <p>3.1-33(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>			

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	<p>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 fluid distribution plan for 1 resident (Resident #23) of 3 residents who received hemodialysis.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #23 on 6/13/16 at 2:53 p.m., indicated the following: diagnoses included, but were not limited to, end stage renal disease, Type 2 diabetes mellitus, chronic obstructive pulmonary disease, hypertension, and anxiety disorder.</p> <p>Resident #23 was admitted to the facility on 4/15/16.</p> <p>A physician's order for Resident #23, dated 4/15/16, indicated a Renal Diet with double meats. The order also indicated a 1500 ml (milliliter) fluid restriction.</p> <p>A Nutrition Evaluation for Resident #23, dated 4/20/16, indicated he received a Renal Diet with double meats and a 1500</p>	F 0279	<p>F279 DEVELOP COMPREHENSIVE CARE PLANS</p> <p>i. <u>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:</u></p> <p>-</p> <p>1. Resident #23 no longer has an order for fluid restrictions.</p> <p>II. <u>How are other residents having the potential to be affected by the same deficient practice and What corrective actions will be taken:</u></p> <p>1. A review of all residents' orders was completed by licensed nursing staff. Orders reflect that no other residents have an order for fluid restrictions.</p> <p>III. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u></p> <p>1. The facilities Registered Dietician will be consulted regarding any resident admitted with orders for fluid restriction, as well as, any existing</p>	07/15/2016	

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	<p>ml fluid restriction.</p> <p>Review of the clinical record for Resident #23 did not include a fluid distribution plan.</p> <p>A facility Nurse Tech Information Kardex for Resident #23 indicated he was to receive double meat and only 1500 cc (cubic centimeters) fluid daily.</p> <p>A Tray Ticket for Resident #23, provided by the Certified Dietary Manager on 6/14/16 at 10:45 a.m., indicated he received a Renal Diet with a fluid restriction of 1500 ml daily.</p> <p>A facility care plan for Resident #23, dated 4/20/16, indicated the problem area of nutritional risk related to: COPD, diabetes, end stage renal disease, and anxiety. Approaches and interventions to the problem included, but were not limited to, diet as ordered Renal Diet with 1500 ml fluid restriction, double meats, monitor intake, and non-compliant with fluid restriction.</p> <p>A facility care plan for Resident #23, dated 4/22/16, indicated the problem area of potential for dehydration/fluid maintenance related to end stage renal disease. Approaches to the problem included, but were not limited to, 1500 cc</p>		<p>resident who receives new orders for fluid restriction.</p> <p>2. Education will be provided to both dietary staff and nursing staff regarding fluid restriction, care plans for those residents with fluid restrictions, and implementation of the fluid restriction. (Nursing staff will be educated on how to implement Fluid Restrictions, so that they are able to start implementation in the absence of Dietary Manager.) This education will be completed by licensed administrative nursing staff including the Director of Nursing and the Dietary Manager. The education will include a review of the policy and information on how to contact the licensed dietitian.</p> <p>IV. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place:</u></p> <p>1. The Director of Clinical Services, or her designee, will review all new orders, M-F, to ascertain whether any new orders for Fluid Restrictions have been received and properly implemented.</p> <p>2. The Director of Clinical Services, or her designee, will review all new admission records, M-F, to ascertain whether any newly admitted resident has an</p>		

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	<p>daily fluid restriction, encourage to consume fluids offered, and consultation as appropriate with RD (Registered Dietitian).</p> <p>The Regional Director of Clinical Services #2 was interviewed on 6/14/16 at 10:26 a.m. During the interview, she indicated a fluid restriction order was clarified on the Medication Administration Record defining the amount of fluids to be given by nursing and the amount of fluids to be given by dietary daily. She also indicated the amount of fluids to be given by nursing was divided by shift with nursing documenting the cc's given to the resident during each shift.</p> <p>The Certified Dietary Manager was interviewed on 6/14/16 at 10:45 a.m. During the interview she indicated a fluid distribution plan had not been developed for Resident #23. She also indicated his fluid restriction had been added to his tray ticket, but it was the responsibility of nursing to determine the amount of milliliters assigned daily to nursing and the amount of milliliters assigned to dietary. She further indicated once dietary received the amount of milliliters assigned to the dietary department, the fluids would be divided between each meal.</p>		<p>order for fluid restrictions, and that if so, they have been properly implemented.</p> <p>3. For all residents having an order for Fluid Restrictions, the Director of Clinical Services, or her designee, will perform a weekly review of the Clinical Record, to ensure proper implementation of Plan of Care for Fluid Restrictions. This will continue for a period of three months, after which the review will become bi-weekly for a period of three months. Audit will continue on a monthly basis after that point, unless determined to be needed more frequently by QAPI Committee.</p> <p>4. Any areas of continued concern related to Fluid Restrictions will be reported to QAPI Committee for review and recommendation. QAPI Team will make additional recommendations where needed and the Interdisciplinary Team will follow those recommendations.</p> <p>5. Regional Registered Dietician will review medical records of all residents with an order for fluid Restrictions each month and make recommendations as needed.</p> <p>V. <u>By what date will the systemic changes be completed?</u> A. July 15, 2016</p>				

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F 0282 SS=E Bldg. 00	<p>The Director of Nursing was interviewed on 6/14/16 at 12:18 p.m. During the interview, she indicated the facility had not developed a fluid distribution plan for Resident #23. She also indicated it was the responsibility of nursing to determine the fluid distribution plan.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on observation, interview and record review, the facility failed to follow physician orders for a Renal Diet with double protein for 1 resident (Resident #47), a fluid restriction for 1 resident (Resident #23), and a diet of 1/2 protein, double bread, starch, vegetables, fruit, and dessert for 1 resident (Resident #29).</p> <p>B. Based on observation, interview and record review, the facility failed to ensure</p>	F 0282	<p>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>i. <u>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:</u></p> <p>-</p> <p>1. Double Protein: Resident is being served diet as ordered at all meals.</p> <p>2. Fluid Restrictions: Resident no longer has an order for fluid restrictions.</p>	07/15/2016

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	<p>fresh ice water was available as care planned on 1 of 2 halls observed for having had ice water passed. (Resident # 2, Resident #17)</p> <p>C. Based on observation, interview and record review, the facility failed to ensure splint application and restorative programs were provided as care planned for 1 of 3 residents reviewed for range of motion. (Resident #41)</p> <p>Findings include:</p> <p>A.1. Review of the clinical record for Resident #47 on 6/10/16 at 9:49 a.m., indicated the following: diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, diabetes mellitus, hypertension, and chronic obstructive pulmonary disease.</p> <p>Resident #47 was re-admitted to the facility on 3/18/16.</p> <p>A Nutrition Evaluation Initial and Annual assessment for Resident #47, dated 3/31/16, indicated he received dialysis. The assessment also indicated a recent below the knee amputation. The assessment recommended large portions of protein at meals and Nepro (nutrition</p>		<p>3. Diet of ½ Protein, double bread, starch, vegetables, fruit and dessert is being served at all meals.</p> <p>4. Fresh ice water is available as care planned.</p> <p>5. Restorative Program is being provided as care planned and splint application is performed as care planned.</p> <p>6. New diet order was received on 6-29-16. Resident being served diet as ordered.</p> <p>II. <u>How are other residents having the potential to be affected by the same deficient practice and What corrective actions will be taken:</u></p> <p>- (Letters directly correspond to those in Section I, above.)</p> <p>1. All residents have the potential of being affected, related to all residents have specific diet orders that must be served as ordered. All residents diet orders have been reviewed by the Dietary Manager and the Director of Clinical Services to ensure that the diets being served match the physician's orders. Tray cards, which provide dietary line staff with the physician's ordered diet, were reviewed to ensure that all information on the tray cards match the physician's orders.</p>	

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	<p>supplement for dialysis) 1-2 cans daily due to low protein levels, wound healing, and dialysis.</p> <p>A physician's order for Resident #47, dated 3/31/16, indicated he received a Diabetic No Added Salt Renal diet.</p> <p>A physician's order for Resident #47, dated 4/12/16, indicated to add double portion of proteins at meals and to start 1 can Nepro BID.</p> <p>A Nutrition Progress Note for Resident #47, dated 4/14/16 and written by the Registered Dietitian, indicated he received double portions of meat at meals and 1 can of Nepro BID added on 4/12/16.</p> <p>A physician's order for Resident #47, dated 5/4/16, indicated a protein snack every day.</p> <p>A physician's order for Resident #47, dated 5/10/16, indicated to follow a low sodium, modified K+ (potassium), and phosphorus Renal diet with double protein (not carbohydrates) at all meals.</p> <p>A facility Nurse Tech Information Kardex for Resident #47 indicated he was to receive double protein, a protein snack daily, and Nepro per order.</p>		<p>2. Review of Physicians orders revealed that no other resident in facility currently has an order for fluid restrictions. Any resident who receives an order for fluid restrictions, or is admitted with an order for fluid restrictions, however, would have the potential to be affected.</p> <p>3. All residents have the potential of being affected, related to all residents have specific diet orders that must be served as ordered. All residents diet orders have been reviewed by the Dietary Manager and the Director of Clinical Services to ensure that the diets being served match the physician's orders. Tray cards, which provide dietary line staff with the physician's ordered diet, were reviewed to ensure that all information on the tray cards match the physician's orders.</p> <p>1. All residents able to have water at bedside have the potential to be affected. Water is available for all residents able to have it at bedside at this time.</p> <p>2. All residents enrolled in the Restorative Nursing Program have the potential to be affected by this deficient practice. Residents enrolled in the Restorative Program are currently receiving Restorative Services as Care planned.</p>				

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	<p>A Tray Ticket for Resident #47, provided by the Certified Dietary Manager (CDM) on 6/14/16 at 10:45 a.m., indicated he received a Controlled Carbohydrate Diabetic No Added Salt diet with double proteins with each meal.</p> <p>During an observation of the lunch meal on 6/9/16 at 12:00 p.m., Resident #47 was observed to receive a meal tray in his room. His lunch meal consisted of: 2 sections of meatloaf with ketchup, mashed potatoes, Brussels sprouts, 1 dinner roll/bread, and chilled peaches.</p> <p>Dietary Spreadsheets for the lunch meal on 6/9/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following for a Renal Diet: a 4 ounce square of meatloaf with no tomato.</p> <p>During an observation on 6/10/16 at 12:22 p.m., Resident #47 was observed eating his lunch meal in his room. He was observed to have only 1 portion of fish on his plate, and acknowledged he had only received 1 portion of fish. He also received Tater Tots, creamy coleslaw, dinner roll/margarine, and a chocolate brownie.</p> <p>Dietary Spreadsheets for the lunch meal on 6/10/16, provided by the CDM on</p>		<p>3.All residents have the potential of beingaffected, related to all residents have specific diet orders that must be served as ordered. All residents dietorders have been reviewed by the Dietary Manager and the Director of ClinicalServices to ensure that the diets being served match the physician'sorders. Tray cards, which providedietary line staff with the physician's ordered diet, were reviewed to ensurethat all information on the tray cards match the physician's orders.</p> <p>III. <u>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</u></p> <p>- (Lettersdirectly correspond to letters in Sections I and ii, above.)</p> <p>1. Re-education will be provided for nursingstaff and dietary staff regarding:</p> <p>1. Dietarystaff serving meals according to the tray ticket for each resident.</p> <p>2.Licensed and unlicensed nursing staff will beeducated on validation on tray accuracy when serving meal trays. The educationwill be completed by a licensed administrative nurse.</p> <p>1. Re-education of Dietary Staff and NursingStaff by Registered</p>		

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	<p>6/14/16 at 10:45 a.m., indicated the following for a Renal Diet: noodles instead of mashed potatoes and sherbet instead of a chocolate brownie.</p> <p>During an observation of the lunch meal on 6/13/16 at 11:40 p.m. in the facility kitchen, Resident #47's meal tray was prepared. He was observed to receive double portions of rice pilaf, a serving of turkey with a small amount added, peas, dinner roll/bread, and a dessert bowl of chilled pears. He was not observed to receive double meat as ordered.</p> <p>Dietary Spreadsheets for the lunch meal on 6/13/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following for a Renal Diet: rice instead of rice pilaf and 1 cup of chilled pears instead of 1/2 cup of chilled pears.</p> <p>A facility care plan for Resident #47, dated 3/18/16, indicated the problem area of resident at risk for alteration in nutrition/hydration related to End Stage Renal Disease dialysis and fluctuations in weight related to dialysis. Approaches to the problem included, but were not limited to, diet per order, obtain food likes or dislikes, monitor intake, double portions of protein, offer protein snack daily, and (family member) will bring in foods he likes.</p>		<p>Dietician and or the Director of Nursing regarding FluidRestriction Implementation, including initial fluid distribution, Plan of Care, Departmental Responsibilities regarding initiation of fluid restrictions, and documentation of fluid intake.</p> <p>2. Re-education will be provided for nursing staff and dietary staff regarding:</p> <p>1. Dietary staff serving meals according to the tray ticket for each resident.</p> <p>2. Nursing staff reviewing tray tickets prior to serving meals to the residents for tray accuracy.</p> <p>1. Licensed and unlicensed nursing staff re-educated by administrative nursing staff regarding hydration program and nursing responsibility related to passing ice water each shift. This includes:</p> <p>1. Creation and implementation of new procedure regarding use of plastic water pitcher that retain the integrity of the ice much longer than the Styrofoam cups did, making the water more palatable for a longer period of time. (Implemented June 14-2016) ATTACHMENT A</p> <p>2. Expectations regarding frequency of ice water passes.</p>	

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	<p>The CDM was interviewed on 6/14/16 at 2:01 p.m. During the interview, she indicated she had not received the physician's order for a Renal Diet for Resident #47. She also indicated nursing completed a Diet Order and Communication form from physician orders and provided the form to dietary. She further indicated dietary made changes to resident's diets based on the Diet Order and Communication form. The CDM also indicated if she had received the physician order for Resident #47, dated 5/10/16, she would have asked nursing to clarify the order, and would have changed his diet to a Renal Diet with No Added Salt.</p> <p>2. Review of the clinical record for Resident #23 on 6/13/16 at 2:53 p.m., indicated the following: diagnoses included, but were not limited to, end stage renal disease, Type 2 diabetes mellitus, chronic obstructive pulmonary disease, hypertension, and anxiety disorder.</p> <p>Resident #23 was admitted to the facility on 4/15/16.</p> <p>A physician's order for Resident #23, dated 4/15/16, indicated a Renal Diet with double meats. The order also</p>		<p>1. Nursingstaff, including Restorative Nursing staff re-educated regarding RestorativeNursing Program, including:</p> <p>1. Responsibilities of implementation ofRestorative Nurse and Restorative CNAs.</p> <p>2. Responsibilities of non-Restorative CNAs relatedto splint application and Range of Motion for residents participating in theRestorative Nursing program.</p> <p>3. As of 6-14-2016, hiring and orientation ofadditional Restorative CNA, who will provide Restorative care when primary RestorativeCNA is not scheduled.</p> <p>IV. <u>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e. What quality assurance program will be put into place:</u></p> <p>(Letters directly correspond to letters in Sections I andii, above.)</p> <p>1. DietaryManager will perform weekly audits of 15 prepared trays to ensure that dietsare being served as ordered. This willcontinue for a period of 4 weeks, then biweekly for a period of 4 weeks, thenmonthly for a period of 3 months. Afterthat time, audits will continue</p>		

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	<p>indicated a 1500 ml (milliliter) fluid restriction.</p> <p>A Nutrition Evaluation for Resident #23, dated 4/20/16, indicated he received a Renal Diet with double meats and a 1500 ml fluid restriction.</p> <p>A facility Nurse Tech Information Kardex for Resident #23 indicated he was to receive double meat and only 1500 cc (cubic centimeters) fluid daily.</p> <p>A Tray Ticket for Resident #23, provided by the CDM on 6/14/16 at 10:45 a.m., indicated he received a Renal Diet with a fluid restriction of 1500 ml daily.</p> <p>A facility care plan for Resident #23, dated 4/20/16, indicated the problem area of nutritional risk related to: chronic obstructive pulmonary disease, diabetes, end stage renal disease, and anxiety. Approaches and interventions to the problem included, but were not limited to, diet as ordered - Renal Diet with 1500 ml fluid restriction, double meats, monitor intake, and non-compliant with fluid restriction.</p> <p>A facility care plan for Resident #23, dated 4/22/16, indicated the problem area of potential for dehydration/fluid maintenance related to end stage renal</p>		<p>randomly, unless otherwise recommended by the QAPI Committee.</p> <p>2. Nocurrent residents in facility with fluid restrictions. Physician's orders, which would include those for fluid restrictions, will be reviewed by Interdisciplinary team M-F for implementation, appropriate Plan of Care and communication to staff using the Kardex/MAR/TAR, Dietary Communication Form.</p> <p>1. Dietary Manager will perform weekly audits of 15 prepared trays to ensure that diets are being served as ordered. This will continue for a period of 4 weeks, then biweekly for a period of 4 weeks, then monthly for a period of 3 months. After that time, audits will continue randomly, unless otherwise recommended by the QAPI Committee.</p> <p>1. Members of Management Team will perform Mock Survey Rounds daily to ensure residents who are able to have fresh ice water in their rooms. Results of Mock Survey rounds to be reported to Interdisciplinary team, including Administrator, daily M-F.</p> <p>2. Restorative Nurse, or her designee, will perform weekly audit of Restorative Nursing Documentation on the</p>	

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	<p>disease. Approaches to the problem included, but were not limited to, 1500 cc daily fluid restriction, encourage to consume fluids offered, and consultation as appropriate with RD (Registered Dietitian).</p> <p>The Regional Director of Clinical Services #2 was interviewed on 6/14/16 at 10:26 a.m. During the interview, she indicated a fluid restriction order was clarified on Medication Administration Record defining the amount of fluids to be given by nursing and the amount of fluids to be given by dietary. She also indicated the amount of fluids to be given by nursing was divided by shift with nursing documenting the cc's given to the resident during each shift.</p> <p>The CDM was interviewed on 6/14/16 at 10:45 a.m. During the interview, she indicated a fluid distribution plan had not been developed for Resident #23. She also indicated his fluid restriction had been added to his tray ticket, but it was the responsibility of nursing to determine the amount of milliliters assigned daily to nursing and the amount of milliliters assigned to dietary. She further indicated once dietary received the amount of milliliters assigned to the dietary department, the fluids would be divided between each meal.</p>		<p>Restorative FlowRecord. Audit will be done for eachresident on Restorative Nursing Program each week for a period of 4 weeks. At that time, audit will be performedbi-weekly for a period of 4 weeks, then monthly for a period of 4 months. After that time, audits will continuerandomly, unless otherwise recommended by the QAPI Committee.</p> <p>1.Re-education will be provided for nursing staffand dietary staff regarding:</p> <p>1. Dietarystaff serving meals according to the tray ticket for each resident.</p> <p>2.Nursing staff reviewing tray tickets prior to serving the resident meal trays.</p> <p>V. <u>By what date will the systemic changes be completed?</u> A. July 15, 2016</p>		

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	<p>3. Review of the clinical record for Resident #29 on 6/13/16 at 8:37 a.m., indicated the following: diagnoses included, but were not limited to, profound mental retardation, phenylketonuria (error of metabolism), ADHD (attention deficit/hyperactivity disorder), pica (ingestion of non-food items) , aphasia (inability to communicate verbally), and history of aspiration (food/liquids breathed into the airway).</p> <p>A physician's order for Resident #29, dated 4/1/16, indicated to give double bread, starch, vegetables, fruits and desserts with all meals. The order also indicated 1/2 portions of protein at all meals.</p> <p>A Nutritional Review for Resident #29, dated 5/17/16, indicated a current diet of Mechanical Soft with double bread, starch, vegetable, and fruit with 1/2 portions of protein.</p> <p>A Nurse Tech Information Kardex for Resident #29 indicated he received a Mechanical Soft Diet. The Kardex also indicated to see tray ticket.</p> <p>A Tray Ticket for Resident #29, provided by the CDM on 6/14/16 at 10:45 a.m.,</p>			

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	<p>indicated he received a Mechanical Soft Diet with 1/2 proteins and double breads, starches, vegetables, fruits and desserts with each meal.</p> <p>During an observation of the lunch meal on 6/8/16 at 12:07 p.m. in the dining room, Resident #29 was observed seated in his wheelchair at a dining room table. He was observed to receive 2 glasses of fruit punch which he consumed immediately. He then left the dining room before receiving his meal tray.</p> <p>During an observation of the lunch meal on 6/10/16 at 12:11 p.m. in the dining room, Resident #29 received 2 glasses of fruit punch and a lunch tray of: 1/2 piece of fish, Tater Tots, a bowl of coleslaw, and a Mechanical Soft chocolate brownie dessert. There were no double servings of tater tots, coleslaw, or the dessert. There was no dinner roll/bread on his plate.</p> <p>Dietary Spreadsheets for the lunch meal on 6/10/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 3 ounces of ground fish, 1/2 cup of Tater Tots, 1/2 cup of creamy coleslaw, 1 dinner roll/bread, and 1 Mechanical Soft chocolate brownie.</p> <p>During an observation of the breakfast</p>			

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	<p>meal in the dining room on 6/13/16 at 8:14 a.m., Resident #29 received a bowl of cold cereal, 1 slice of french toast, and ground sausage. There were no double servings of cereal or French toast. The amount of ground sausage served appeared to be the same serving size of other residents who received ground sausage.</p> <p>Dietary Spreadsheets for the breakfast meal on 6/13/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 1 slice of French toast and 1 ground sausage patty.</p> <p>During an observation of the lunch meal on 6/13/16 at 12:20 p.m. in the dining room, Resident #29 was observed to receive a plate of a smaller portion of turkey, a larger portion of rice and peas in his divided plate, and a bowl of fruit. There was no double serving of fruit and no dinner roll/bread on his plate.</p> <p>Dietary Spreadsheets for the lunch meal on 6/13/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 3 ounces of ground turkey, 1/2 cup of rice pilaf, 1/2 cup green peas, 1 dinner roll/bread, and 1/2 cup of chilled pears.</p>			

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	<p>During an observation of the breakfast meal in the dining room on 6/14/16, Resident #29's meal tray was placed at his table setting. His breakfast meal consisted of a small servings of eggs, a bowl of cold cereal, 1 slice of toast and 2 glasses of beverages. There were no double servings of cereal or toast. There was no coffee cake on his plate.</p> <p>Dietary Spreadsheets for the breakfast meal on 6/14/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 1/4 cup scrambled eggs and 1 square of coffee cake.</p> <p>A facility care plan for Resident #29, with a review date of 5/17/16, indicated the problem area of Nutritional Risk related to Mechanically altered, Cognitive Loss, Behavioral problems, Therapeutic Diet, and Mental Retardation. Approaches to the problem included, but were not limited to, diet as ordered, monitor weight, monitor intake, honor food preferences as applicable, and encourage fluids.</p> <p>The CDM was interviewed on 6/14/16 at 1:48 p.m. During the interview, she indicated Resident #29 did not always eat everything served so he was not always</p>						

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	<p>provided with double servings.</p> <p>The Director of Nursing was interviewed on 6/15/16 at 12:29 p.m. During the interview, she indicated physician orders should be followed.</p> <p>A current facility policy "Physician's Orders", dated 11/30/14 and provided by the Director of Nursing on 6/14/16 at 2:42 p.m., indicated "...A Clinical Nurse shall transcribe and review all physician orders in order to effect their implementation...Order should include the following: Diet (including nutritional supplements, if applicable)...."</p> <p>B.2. On 6/9/16 at 9:00 a.m., Resident #17 was interviewed. The resident indicated "sometimes they pass ice water and sometimes they don't."</p> <p>On 6/9/16 at 9:03 a.m., Resident #2 was interviewed. The resident indicated there was "no real schedule to when we get fresh water, sometimes we get it, sometimes we don't."</p> <p>On 6/10/16 at 8:52 a.m., a Styrofoam cup with a date of 6/9/16 written on the side of it was observed on top of Resident #2's cabinet. No ice was observed in the cup and the water level appeared to be at a 1 inch depth in the</p>			

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	<p>bottom of the cup.</p> <p>On 6/10/16 at 12:02 p.m., Resident #2's glass was still observed with the date of 6/9/16, no ice was observed and the water level remained unchanged as observed at 8:52 a.m.</p> <p>On 6/10/16 at 1:45 p.m. and 2:30 p.m., Resident #2's Styrofoam cup was observed at his bedside with the date of 6/9/16 written on the side of the cup. No ice was observed in the cup and the same amount of water was observed in the glass as when observed at 8:52 a.m. and 12:02 p.m. Ice water was not observed to have been passed on the east hall on the day shift on 6/10/16.</p> <p>On 6/13/16 at 9:00 a.m., 10:30 a.m., 11:30 a.m. and 12:30 p.m., 1:09 p.m., 2:30 p.m. and 2:42 p.m., Resident #2 was observed to have a Styrofoam cup of water observed at his bedside. The cup had a date written on the side of 6/12/16. No ice was observed in the cup and the water level remained unchanged in the cup, which was 1 inch depth in the bottom of the cup.</p> <p>On 6/14/16 at 2:40 p.m., the DON (Director of Nursing) provided a copy of a current plan of care for Resident #2 and Resident #17. The care plan for both</p>			

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	<p>Resident #2 (dated 4/5/16) and Resident #17 (dated 4/26/16) addressed the problem of "Fluid Volume Deficit, risk for" and included but was not limited to, the following interventions: "Encourage to consume fluids...Provide water pitcher at bedside..."</p> <p>On 6//14/16 at 2:40 p.m., the DON provided a copy of the Kardex for Resident #2. The Kardex included, but was not limited to, the following: "Fluids...Enc (encourage), keep at R (right) side..."</p> <p>On 6/14/16 at 3:12 p.m. CNA (Certified Nursing Assistant) #11 was interviewed. She indicated she passed ice water twice a shift, at the beginning and the end of each shift.</p> <p>On 6/14/16 at 3:30 p.m., the Regional Director of Clinical Services #2 provided a current copy of the facility policy and procedure for "Hydration Policy." The policy had an effective date of 11/30/2014 and included, but was not limited to, the following: "...Fluids will be provided daily to all residents...and at bedside..."</p> <p>On 6/15/16 at 12:30 p.m., the DON (Director of Nursing) was interviewed. She indicated it was the expectation of</p>			

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	<p>the facility that all care plans should be followed. She also indicated ice water should be passed at least once a shift.</p> <p>C.1. On 6/10/16 at 10:00 a.m., the clinical record of Resident #41 was reviewed. Diagnoses included but were not limited to the following: Quadriplegia and Anoxic Brain injury. The MDS (minimum data set) Assessment dated 4-5-16, included but was not limited to, the following: total cognition score of 07, which indicated moderately impaired cognition; ambulation in room and corridor did not occur; Functional Range of Motion was impaired on both sides of upper and lower extremities; and received Occupational Therapy during the assessment period.</p> <p>On 6/13/16 at 10:00 a.m., 11:00 a.m., 12:00 p.m., 1:00 p.m. and 2:00 p.m., the resident was observed in bed. The resident was observed to have both of his hands balled up in a fist position with no splints observed on either hand or arm.</p> <p>On 6/14/16 at 9:27 a.m., the Restorative CNA (Certified Nursing Assistant) #12 was interviewed. She indicated she worked 7:30 a.m. to 3:00 p.m., Monday through Friday and sometimes she</p>			

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	<p>worked on Saturday. She indicated she placed elbow/hand splints on Resident #41 around 9:30 a.m. and the resident kept them on until lunch time, which she indicated was around 1:00 p.m. Restorative CNA #12 indicated she performed passive range of motion (staff moving the residents joints with no effort from the resident) on Resident #41's bilateral upper and lower extremities. Restorative CNA #12 indicated Resident #41's fingers will not straighten all the way out. At this time, Restorative CNA #12 indicated yesterday, 6/13/16, and today she had worked as a CNA on the unit. Restorative CNA #12 indicated resident's "just didn't get restorative services today or yesterday." She indicated this was because she was working as a CNA on the floor. She indicated when she worked on the unit as a CNA the resident's assigned CNA was supposed to apply the splints. The Restorative CNA #12 indicated when she was not available to perform the restorative exercises, the floor CNAs do not do the restorative exercises. The Restorative CNA #12 indicated "the residents just don't get it." She indicated it has been about 3 months since she worked the floor last. She indicated she did not work this past weekend, (6/11/16 and 6/12/16). She indicated she did not perform restorative range of motion on</p>						

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	<p>Resident #41 6/13/16, so the resident did not receive restorative services for 3 days. She indicated the resident was "getting stronger." The Restorative CNA #12 indicated Resident #41 was to have restorative services performed 5 days a week. She indicated "the CNAs who routinely work on the unit, don't perform the restorative exercises but they are supposed to apply the splints." The Restorative CNA #12 indicated she had seen an improvement since she's been doing the restorative for Resident #41.</p> <p>On 6/14/16 at 11:25 a.m., the Restorative Nurse #13 was interviewed. She indicated she was the Restorative Nurse and oversaw the restorative program. She said she reviewed the program with the Restorative CNA #12. Restorative Nurse #13 indicated when Restorative CNA #12 worked the floor or was not at the facility, no staff performed the restorative exercise programs for the residents. She indicated the facility "is looking at this."</p> <p>On 6/14/16 at 2:30 p.m., CNA #14 was interviewed. She indicated the Restorative CNA did the restorative exercises but if she were to do the restorative exercises, she "thinks 5 reps (repetitions) to each bue (bilateral upper extremity) and ble (bilateral lower</p>			

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	<p>extremities)." CNA #14 indicated the resident's braces were to be on 30 minutes a day.</p> <p>On 6/15/16 at 8:22 a.m., Restorative Nurse #13 provided the restorative tracking forms for March 2016, April 2016, May 2016 and June 2016. At this time, Restorative Nurse #13 was interviewed. She indicated these were the forms the Restorative CNA documented splint application and range of motion exercises. The March 2016 Restorative Tracking form included, but was not limited to, the following: the program of "PROM (passive range of motion) with the goal of "to prevent contractures of arms and legs" and the program of "wear hand splint to B (bilateral) hand for 2 to 4 hours" with the goal of "to prevent bilateral hands from contracting and not being able to open..." Documentation was lacking from 3/19/16 to 3/27/16 (9 days) of the PROM or application of hand splints. Documentation was also lacking from 5/28/16 -5/30/16 (3 days) of PROM or application of splints. Documentation indicated the resident did receive PROM and application of splints on 5/31/16 - 6/3/16 (4 days).</p> <p>On 6/15/16 at 9:25 a.m., Restorative Nurse #13 was interviewed. She</p>			
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	<p>indicated the reason documentation was lacking for Resident #41's restorative exercises and splint application from 3/19/16 - 3/27/16 was because Restorative CNA #12 must have been on vacation and no staff performed these services in her absence for the residents. Restorative Nurse #13 indicated the reason the Resident #41 did not receive restorative services on 5/30/16 was because Restorative CNA #12 was off for the holiday and no staff performed these services for residents in her absence.</p> <p>On 6/15/16 at 10:20 a.m., the DON (Director of Nursing) was interviewed. She indicated when the Restorative CNA was not in the facility, the CNAs working on the floor were to apply the splints and then the CNAs documented the splint application on the resident's TAR (treatment administration record). At this time, the DON was unable to find documentation of Resident #41's splint application on his TAR.</p> <p>On 6/15/16 at 12:30 p.m., the DON (Director of Nursing) was interviewed. She indicated it was the expectation of the facility that all care plans should be followed.</p> <p>3.1-35(g)(2)</p>			

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F 0323 SS=E Bldg. 00	<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 personal care products and personal hand sanitizer were stored securely. This deficient practice had the potential to affect the 11 confused and independently mobile residents of the 43 residents who resided in the facility.</p> <p>Findings include:</p> <p>An observation of the unattended East/South hall medication cart on 6-8-2016 at 10:03 a.m., indicated the cart was parked outside room 127 with a 1 ounce bottle of hand sanitizer on the top of the cart. Three residents were observed to be sitting in the vicinity of the cart.</p> <p>An observation of the unattended nurse</p>	F 0323	<p>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES i. <u>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:</u> _</p> <p>1. Facility-wide "sweep" was performed to identify and remove any hazards, or chemicals from residents' rooms, nurse's carts and any other area that may be accessible to residents. II. <u>How are other residents having the potential to be affected by the same deficient practice and What corrective actions will be taken:</u> _</p> <p>1. Confused residents have the potential to be affected by the deficient practice. _ III. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u></p> <p>1. Administrator and Director of Clinical Services reviewed the</p>	07/15/2016

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	<p>station with both swinging doors wide open on 6-8-2016 at 12:13 p.m., indicated a 1 ounce bottle of hand sanitizer on the nurse station counter. Two residents were sitting in their wheelchairs, another resident was walking around the nurse station and one other resident was observed to propel himself past the nurse station in his wheelchair.</p> <p>An observation of the unattended nurse station on 6-13-2016 at 9:17 a.m., indicated one of the facility identified confused and independently mobile residents entered the nurse station area.</p> <p>An observation of an unattended linen cart parked in the West hall between rooms 103 and 104 on 6-14-2016 at 4:22 p.m., indicated a 4 ounce container of hand sanitizer was on the shelf between the stacks of towels. A resident identified by the facility as confused and independently mobile was in her wheelchair and touching the cart with her hands.</p> <p>An observation in room 141 on 6-14-2016 at 4:23 p.m., indicated an 8 ounce spray bottle of perineal wash was sitting on an open shelf next to the bathroom doorway. The shelf was about 3 feet off the floor. A label on the</p>		<p>Hazardous Material Storage and Handling/MSDS Policy and Procedure, which was provided to the Survey Team during Survey Process. The policy/procedure is found to be acceptable; however, an addendum has been created to policy that includes a Protocol for the storage of Personal Care items, which will allow the storage of Personal Care items in "Ziploc" baggies, either in resident drawers, closet or bathroom, depending upon resident preference. The Quality Assurance Performance Improvement Committee adopted this policy on 6-29-16 and Administrative Team was educated on policy at that time. ATTACHMENT B All staff will be educated on Storage Protocol of Personal Care Items.</p> <p>2. Resident education provided for to Resident regarding hazardous items in room. Understanding was verbalized.</p> <p>3. All staff will be educated on Hazardous Materials Storage and Handling</p> <p>IV. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place:</u></p> <p>1. Administrative Team members will perform daily rounds, Monday through Friday on every room, shower room and bathroom, checking for any hazardous items or chemicals, and to ensure that</p>	

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	<p>perineal wash indicated "Caution for external use only." A review of the June 2016 recapitulation for the resident in room 141, indicated one of the diagnoses included Pica (ingestion of non-food items). The resident who resided in room 141 was identified by the facility as confused and independently mobile.</p> <p>An observation in the bathroom of room 101 on 6-14-2016 at 4:37 p.m., indicated a 1.8 ounce deodorant stick, two 4 ounce bottles of mouthwash and two 1.5 ounce containers of antiperspirant were on the bathroom counter. Each product was labeled with "keep out of reach of children." At this time, a resident identified by the facility as being confused and independently mobile was observed to wander in West hall into rooms 105, 111 and 110 and back to her room 105.</p> <p>An observation in room 124 on 6-15-2016 at 8:44 a.m., indicated a 10 ounce spray bottle of detangler was out on the bedside table and had "keep out of reach of children" on the label. A non-facility foam soap dispenser was observed on the bathroom counter.</p> <p>An interview with the resident in 101-2 on 6-15-2016 at 8:45 a.m., indicated he was standing in West hall and said the</p>		<p>Protocol for storage of personal care items is being followed. These rounds will be performed by Clinical Care Liaison on 5-6 random rooms during weekends per schedule.</p> <p>2. Trends of non-compliance with Hazardous Material Storage and Handling, Including Addendum to include Protocol for Storage of Personal Care items will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.</p> <p>V. <u>By what date will the systemic changes be completed?</u> A. July 15, 2016</p>	

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	<p>resident from room 105 just came into his room and stole his milk. (The resident in room 105-1 was identified by the facility as confused and independently mobile.)</p> <p>An observation in room 110 on 6-15-2016 at 8:54 a.m., indicated a 1.5 ounce container of antiperspirant on the resident's overbed table. On the bathroom counter, a 2 ounce tube of denture adhesive and 5 effervescent denture cleanser tablets were observed. An interview with the resident in room 110 indicated the resident from room 105 had wandered into her room and would take her water.</p> <p>An observation in room 120 on 6-15-2016 at 9:01 a.m., indicated a container of disinfecting wipes was on a low table in her room.</p> <p>An observation in room 123 on 6-15-2016 at 9:02 a.m., indicated there was a 9.7 ounce can of air freshener on the bedside table with "keep out of reach of children" on the label.</p> <p>An interview with the DON (Director of Nursing and the Regional Director of Clinical Services #2 on 6-15-2016 at 12:00 p.m., indicated the staff try to check to be sure that these personal items were put away, but the residents who</p>			

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	<p>were alert and oriented want their stuff out.</p> <p>A list of confused and independently mobile residents was provided by the DON on 6-14-2016 at 4:50 p.m. The list indicated there were 11 residents who were confused and independently mobile.</p> <p>MSDS (Material Safety Data Sheet) were provided by the DON on 6-15-2016 at 1:50 p.m. and provided the following information:</p> <p>A MSDS (Material Safety Data Sheet) for a brand name deodorant updated June 2011, indicated "...accidental ingestion of product may necessitate medical attention...keep out of reach of children...."</p> <p>An undated MSDS for a brand name soap product, all varieties, indicated "...if large amounts are ingested, may cause nausea vomiting or diarrhea...call a physician or Poison Control Center...."</p> <p>A MSDS for a brand name denture adhesive with a revision date of 6-29-2015, indicated "...causes eye irritation...rinse cautiously with water for several minutes...if eye irritation persists get medical advice/attention...ingestion...call a</p>			

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	<p>physician or poison control center immediately if overdosed...."</p> <p>An undated MSDS for disinfecting wipes indicated "...Keep out of reach of children...."</p> <p>A MSDS for a brand name fabric refresher dated 8-30-2004 indicated for "ingestion...possible mild gastrointestinal irritation with nausea, vomiting, and/or diarrhea...if eye contact occurs, rinse well with water...KEEP OUT OF REACH OF CHILDREN...."</p> <p>A MSDS for a brand name mouthwash dated 10-28-2010 indicated "...ingestion of large amounts may produce signs of alcohol intoxication an stomach irritation...."</p> <p>A current policy titled, "Hazardous Material Storage and Handling/MSDS" dated 11-30-2014 and provided by the DON on 6-15-2016 at 1:50 p.m., indicated "...hazardous materials shall be stored and handled in a manner that shall minimize the risk of injury or property damage...never leave containers of cleaning chemicals and other hazardous material unattended...store in locked cabinets and closets when not in use...."</p> <p>3.1-45(a)(1)</p>			

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F 0325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review the facility failed to provide additional interventions and failed to provide his diet with doubles as ordered for 1 resident (Resident #29) with a significant weight loss</p> <p>Findings include: Review of the clinical record for Resident #29 on 6/13/16 at 8:37 a.m., indicated the following: diagnoses included, but were not limited to, profound mental retardation, phenylketonuria (error of metabolism), ADHD (attention deficit/hyperactivity disorder), pica (ingestion of non-food items), aphasia</p>	F 0325	<p>F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE i. <u>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:</u> 1. On 6-21-16, the Certified Dietician with Health Care Services, reviewed residents medical record, dietary orders and nutritional status. All current dietary interventions were reviewed and deemed to be appropriate. No new dietary interventions were recommended at this time. II. <u>How are other residents having the potential to be affected by the same deficient practice and What corrective actions will be taken:</u> _</p>	07/15/2016

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	<p>(inability to communicate verbally), and history of aspiration (food/liquids breathed into the airways).</p> <p>Facility weights for Resident #29 indicated the following: 132.9 pounds on 9/24/15, 128 pounds on 10/21/15, 123.7 pounds on 12/7/15, and 123.3 pounds on 1/8/16. Calculations by the Surveyor indicated a weight loss of 7.22 % in 4 months.</p> <p>A physician's order for Resident #29, dated 10/7/15, indicated Remeron 15 mg (milligrams) HS (hour of sleep) as an appetite stimulant.</p> <p>A Nutrition Evaluation for Resident #29, dated 10/15/15, indicated a current weight of 127.9 pounds, a decrease of 5 pounds over 30 days. The evaluation also indicated a usual weight of 130 pounds with a goal of a gradual weight gain. The note also indicated he received a Mechanical Soft diet with thin liquids with a good intake. The note further indicated he received Remeron as an appetite stimulant.</p> <p>A previous Nutritional Review for Resident #29, dated 1/29/15, indicated a usual body weight of 140-160 pounds and an ideal body weight range of 132-156 pounds.</p>		<p>1. On 6-30-16, the Certified Dietician and Certified Dietary Manager and Director of Clinical Services reviewed weights for all current residents to establish which residents, if any, triggered for significant weight loss (greater than 5% loss in 1 month, greater than 7.5% in 3 months or greater than 10% loss in 6 months)</p> <p>2. Each week, all residents in the facility will be evaluated for significant weight loss. Any resident experiencing significant weight loss, as indicated by the above guidelines, will be reviewed by the Interdisciplinary Team, including Certified Dietary Manager and Director of Clinical Services for new needed interventions. The Certified Dietician will be consulted as needed for consultations as indicated by the interdisciplinary team.</p> <p>III. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u></p> <p>1. Certified Dietician will perform monthly review of medical records for all residents triggering for significant weight loss. The Dietitian will review current interventions that have been initiated by interdisciplinary team, including the Certified Dietary Manager and make recommendations as needed. IV. <u>How the corrective action(s) will be monitored to</u></p>				

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	<p>An Interdisciplinary Progress Notes, dated 1/6/16 and written by the Registered Dietitian, indicated a current weight of 123.7 pounds, with a usual body weight of 118 pounds to 132 pounds. The note also indicated he continued to receive a Mechanical Soft diet with thin liquids and Phenyl-Free (food powder for people with phenylketonuria) 3 scoops QID (four times a day) and Remeron 15 mg HS.</p> <p>Facility weights for Resident #29 indicated the following: 130 pounds on 2/3/16, 116.6 pounds on 3/14/16, 117.9 pounds on 3/24/16, 120.5 pounds on 5/7/16, and 118.9 pounds on 6/3/16.</p> <p>An Interdisciplinary Progress Notes, dated 2/17/16 and written by the Registered Dietitian, indicated a current body weight of 130 pounds. The note also indicated a weight gain was desired.</p> <p>An Interdisciplinary Progress Notes, dated 3/16/16 and written by the Registered Dietitian, indicated a current weight of 120 pounds, down significantly x (times) 30 days. The note also indicated he continued to receive a Mechanical Soft Diet with thin liquids, Phenyl-Free at meals, and Remeron at HS. The note further indicated</p>		<p><u>ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place?</u></p> <p>1. Director of Clinical Services, or her designee, will review all residents triggering for weight loss each week and ensure that interventions are in place, as appropriate. The Dietitian will attend/audit the Nutritional Meeting Minutes Monthly for six months to validate appropriate interventions are implemented during the national meetings. _</p> <p>2. Any trends of non-compliance will be reported to the QAPI Committee for review and recommendations.</p> <p>V. <u>By what date will the systemic changes be completed?</u> A. July 15, 2016</p>	

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	<p>interventions remained appropriate. No recommendations were made to provide additional calories related to his weight loss. Calculations by the Surveyor indicated a weight loss of 7.69 % in 30 days.</p> <p>A physician's order for Resident #29, dated 4/1/16, indicated "...give double bread, starch, vegetables, fruits and desserts with all meals..." The order also indicated 1/2 portions of protein at all meals.</p> <p>A Nutritional Review for Resident #29, dated 5/17/16, indicated a current weight of 120.5 pounds, with a usual body weight of 120-130 pounds. The review also indicated an ideal body weight range of 132-156 pounds. The review further indicated a current diet of Mechanical Soft with double bread, starch, vegetable, and fruit with 1/2 portions of protein.</p> <p>A Nurse Tech Information Kardex for Resident #29 indicated he received a Mechanical Soft Diet. The Kardex also indicated to see tray ticket.</p> <p>A Tray Ticket for Resident #29, provided by the Certified Dietary Manager (CDM) on 6/14/16 at 10:45 a.m., indicated he received a Mechanical Soft Diet with 1/2 proteins and double breads, starches,</p>			

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	<p>vegetables, fruits and desserts with each meal.</p> <p>During an observation of the lunch meal in the dining room on 6/8/16 at 12:07 p.m., Resident #29 was observed seated in his wheelchair at a dining room table. He was observed to receive 2 glasses of fruit punch which he consumed immediately. He then left the dining room before receiving his meal tray.</p> <p>During an observation of the lunch meal in the dining room on 6/10/16 at 12:11 p.m., Resident #29 received 2 glasses of fruit punch and a lunch tray of: 1/2 piece of fish, Tater Tots, a bowl of coleslaw, and a Mechanical Soft chocolate brownie dessert. There were no double servings of tater tots, coleslaw, or the dessert. There was no dinner roll/bread on his plate. By 12:25 p.m., he had consumed his chocolate brownie dessert, all his fish and all his tater tots. He was observed running his finger around the inside of the plate to pick up every crumb of fish and Tater Tots he could. He also kept bringing up his drinking glasses to find more fruit punch. He had not eaten any of his coleslaw. At 12:26 p.m., he was provided a third glass of fruit punch which he immediately consumed.</p> <p>Dietary Spreadsheets for the lunch meal</p>			

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	<p>on 6/10/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 3 ounces of ground fish, 1/2 cup of Tater Tots, 1/2 cup of creamy coleslaw, 1 dinner roll/bread, and 1 Mechanical Soft chocolate brownie.</p> <p>During an observation of the breakfast meal in the dining room on 6/13/16 at 8:14 a.m., Resident #29 received a bowl of cold cereal, 1 slice of French toast, and ground sausage. There were no double servings of cereal or French toast. The amount of ground sausage served appeared to be the same serving size of other residents who received ground sausage.</p> <p>Dietary Spreadsheets for the breakfast meal on 6/13/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 1 slice of French toast and 1 ground sausage patty.</p> <p>During an observation of the lunch meal in the dining room on 6/13/16 at 12:20 p.m., Resident #29 was observed to receive a plate of a smaller portion of turkey, a larger portion of rice and peas in his divided plate, and a bowl of fruit. There was no double serving of fruit and no dinner roll/bread on his plate.</p>			

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	<p>Dietary Spreadsheets for the lunch meal on 6/13/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 3 ounces of ground turkey, 1/2 cup of rice pilaf, 1/2 cup green peas, 1 dinner roll/bread, and 1/2 cup of chilled pears.</p> <p>During an observation of the breakfast meal in the dining room on 6/14/16, Resident #29's meal tray was placed at his table setting. His breakfast meal consisted of a small servings of eggs, a bowl of cold cereal, 1 slice of toast and 2 glasses of beverages. There were no double servings of cereal or toast. There was no coffee cake on his plate.</p> <p>Dietary Spreadsheets for the breakfast meal on 6/14/16, provided by the CDM on 6/14/16 at 10:45 a.m., indicated the following serving sizes for a Mechanical Soft Diet: 1/4 cup scrambled eggs and 1 square of coffee cake.</p> <p>A facility care plan for Resident #29, with a review date of 5/17/16, indicated the problem area of Nutritional Risk related to Mechanically altered, Cognitive Loss, Behavioral problems, Therapeutic Diet, and Mental Retardation. Approaches to the problem</p>			

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	<p>included, but were not limited to, diet as ordered, monitor weight, monitor intake, honor food preferences as applicable, and encourage fluids.</p> <p>The Certified Dietary Manager was interviewed on 6/14/16 at 1:48 p.m. During the interview, she indicated Resident #29 did not always eat everything served so he was not always provided with double servings.</p> <p>The Director of Nursing was interviewed on 6/15/16 at 11:09 a.m. During the interview, she indicated she questioned the 2/3/16 weight of 130 pounds for Resident #29 since his weight had been 7 pounds lower the previous month. She also indicated Resident #29 should have been re-weighed based on facility practice. She further indicated the facility was aware of Resident #29's continuing weight loss. She also indicated he received un-scheduled snacks throughout the day, but the type of snacks provided and his consumption of the snacks was not documented.</p> <p>A current facility policy "Weekly Weight Meeting (QualityAssurance), dated 11/30/14 and provided by the Director of Nursing on 6/15/16 at 1:09 a.m., indicated "...Weight loss/triggers - supplements...Weight losses require</p>			

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F 0332 SS=E Bldg. 00	<p>intervention...Triggers (5%, 7.5%, 10%)...."</p> <p>3.1-46(a)(1)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure the medication administration error rate did not exceed 5%, as 5 of 33 medication administration opportunities observed were errors for 2 residents, which resulted in an error rate of 15.15%. (Resident #25 and #58)</p> <p>Findings include:</p> <p>1. An observation of the medication pass for Resident #25 on 6-10-2016 at 9:01 a.m., indicated LPN #10 prepared the 2 tablet medications for the J-tube (jejunostomy tube, a method to instill food and medications to the small</p>	F 0332	<p>F332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>I. <u>What corrective action(s) will be accomplished for those residents found to be affected by the Deficient practice:</u></p> <p>1. Medications have been administered as ordered for both residents</p> <p>2. Resident/Family / and Physician notification have occurred related to medication errors observed for residents. Vital signs with, no s/s distress related to errors.</p> <p>II. <u>How are other residents having the potential to be affected</u></p>	07/15/2016	

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	<p>intestine).</p> <p>A Tylenol with codeine # 2 tablet (for pain) and an ondansetron HCL (for nausea) 4 mg (milligram) tablet were crushed separately and each was placed in a small, plastic medication cup. During an observation of the medication administration through the J-tube for Resident #25 which began at 9:20 a.m., LPN #10 dumped the dry, crushed Tylenol #2 particles into the barrel of the syringe which was attached to the J-tube. There was about 5 ml (milliliters) of water in the barrel of the syringe. LPN #10 was observed to have pinched the tubing to hold the water in the barrel of the syringe and swirled the water with the crushed, white particles. LPN #10 un-pinched the tubing and allowed the water and particles to flow by gravity into the J-tube. An additional 5 -10 ml of water was instilled into the J-tube prior to the next medication. When the crushed ondansetron HCL was administered, the crushed particles were dumped into the barrel of the syringe and into 5 ml of water. LPN #10 had pinched the tubing and swirled the water and crushed particles in the barrel of the syringe. LPN #10 un-pinched the tubing and the solution did not immediately flow. LPN #10 added a little more water and the medication did flow by gravity into the J-tube.</p>		<p><u>by the same deficient practice and</u> What corrective actions will be taken?</p> <p>1. Residents receiving medications have the potential to be affected by the deficient practice.</p> <p>2. Pharmacy Consultant performed Medication Pass Observation for Nurses on 6-30-16; A medication rate of less than 5% was achieved.</p> <p>III. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u></p> <p>1. Director of Clinical Services, or her designee will perform medication pass observations weekly for a period of 6 months to ensure that medications are being administered according to policy and physician's orders. Two med passes will be observed each week, with re-education provided immediately as needed.</p> <p>2. All nurses will be re-educated regarding proper medication administration procedures, including enteral tube administration and nebulizer treatments.</p> <p>IV. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program</u></p>				

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	<p>An interview with LPN #10 on 6-10-2016 at 9:30 a.m., indicated the crushed medications were not normally mixed with water prior to dumping into the barrel of the syringe.</p> <p>2. An observation of the medication pass for Resident #58 on 6-10-2016 at 9:51 a.m., indicated LPN #9 obtained the medications as follows, Bulera 100 mcg (micrograms) inhaler, Duoneb treatment solution for the breathing treatment and a theophylline ER (extended release) 400 mg tablet. The medication card for the theophylline ER was observed to have the following statement "not to be chewed or crushed. Take with food." LPN #9 was observed to give the theophylline to the resident at 9:55 a.m. without food. LPN #9 administered the Duoneb breathing treatment after using the pulse oximeter to assess the pulse and oxygen saturation. The nurse was not observed to assess Resident #58's breath sounds prior to starting or after the breathing treatment was completed at 10:08 a.m.</p> <p>On 6-10-2015 at 10:15 a.m., a review of Resident #58's medications administered during the medication pass, indicated the Bulera inhaler was not given. An interview at the nurse station with LPN</p>		<p><u>will be put into place?</u></p> <p>1. Consultant Pharmacist to perform Medication Administration Observation Monthly for a period of 6 months, with results reported to the Director of Clinical Services.</p> <p>2. Any trends of non-compliance will be reported to the QAPI Committee for review and recommendation.</p> <p>V. <u>By what date will the systemic changes be completed?</u></p> <p>A. July 15, 2016</p>	

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	<p>#9 on 6-10-2016 at 10:16 a.m., indicated LPN #9 still had the Bulera inhaler in her pocket. LPN #9 indicated she did not give the inhaler treatment to the resident. LPN #9 indicated the inhaler was due. LPN #9 was observed to go to Resident #58's room and administered the 2 puffs of Bulera at 10:21 a.m.</p> <p>A review of the June 2016 recapitulation for Resident #58 on 6-10-2016 at 10:39 a.m., indicated an order to "...1)monitor breath sounds before treatment...." and "...2) monitor heart rate and respirations before treatment...."</p> <p>A review of the June 2016 MAR (Medication Administration Record) for Resident #58 which was provided by the DON (Director of Nursing) on 6-13-2016 at 2:38 p.m., indicated no documentation or initials were entered on the MAR for monitoring breath sounds and the heart or respiration rate from the 1st of June through the 13th of June.</p> <p>An interview with the DON on 6-16-2016 at 3:02 p.m., indicated the crushed medications should have each been mixed with water prior to instilling into the enteral tube per the policy. Further interview with the DON, indicated breath sounds and respiration rate should have been assessed before</p>			

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	<p>and after the breathing treatment.</p> <p>A current policy "Medication Administration Via Enteral Tube" dated 11-30-2014 and provided by the Regional Director of Clinical Services #2 on 6-10-2016 at 10:28 a.m., indicated "...finely crush each medication with pill crusher...pour powder into a medication cup with 5-15 cc (cubic centimeters) of water and dissolve...pour one, individual liquefied medication in the syringe and allow gravity to drain medication into the stomach...."</p> <p>A current policy "Nebulizer (small volume nebulizer) revised on 11-1-2015 and provided by the Regional Director of Clinical Services #2 on 6-10-2-16 at 10:28 a.m., indicated "...documentation shall include...breath sounds before and after treatment...respiratory rate before and after treatment...." The procedure indicated, "...assess the resident...establish baseline respiratory rate...breath sounds...assess the resident's response and effectiveness of treatment by assessing breath sounds...."</p> <p>3.1-48(c)(1)</p>			

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F 0371 SS=F Bldg. 00	<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 staff appropriately washed their hands for the recommended amount of time and washed their hands after touching a soiled object. The facility also failed to ensure staff handled resident food in a sanitary manner potentially affecting 43 of 43 residents who received food and beverages prepared by the facility.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the dining room on 6/8/16, the following was observed:</p> <p>At 12:03 p.m., Activities #4 was observed to lather her hands for 11 seconds prior to rinsing.</p> <p>At 12:06 p.m., Certified Nursing</p>	F 0371	<p>IDR requestThe facility would like to request an IDR for F371 and F520. The facility disputes the findings under F371 because the events identified were not widespread. In addition, the facility has submitted an accepted RCA to the state of Indiana and is following the RCA therefore, should not be cited under F520 for quality assurance. Thank you for your consideration. F371 FOOD PROCEDURE/PREPARE/SERVE SANITARY i. <u>Whatcorrective action(s) will be accomplished for those residents found to beaffected by the deficientpractice:</u> A. <u>Proper hand washing, food handlingpractices are being observed for all residents.</u> II. <u>How areother residents having the potential to be affected by the same deficientpractice and Whatcorrective actions will be taken:</u> A. All residents have the potential to beaffected by the deficient practice. B. All staff to</p>	07/15/2016

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	<p>Assistant (CNA) #6 was observed to appropriately wash her hands for the recommended amount of time. She was then observed to pull a dining room chair over to a dining room table with her clean hands, sit down on the chair, and begin to feed a resident her lunch meal.</p> <p>At 12:10 p.m., CNA #6 was observed to get up from the dining room chair where she was seated. She was observed to put hand sanitizer on her hands, then pulled up a dining room chair in-between 2 residents seated at a dining room table with her clean hands, and began to feed them the lunch meal.</p> <p>At 12:13 p.m., CNA #7 was observed to move a dining room chair over with her hands next to a resident and place a clean clothing protector on the resident without washing her hands. She was then observed to appropriately wash her hands for the recommended amount of time and sit down in the dining room chair next to the resident. She used her clean hands to move the dining room chair up closer to the table to assist the resident with his meal tray.</p> <p>2. During an observation of the lunch meal in the dining room on 6/10/16, the following was observed:</p>		<p>be re-educated regarding handwashing technique and food handling andservice. III. <u>Whatmeasures will be put into place or what systemic changes will be made to ensurethat thedeficient practice does not recur:</u> A. Administrative Team member will observe a mealservice each day to ensure policy is being followed regarding hand washing andfood handling. B. _When non-compliance is observed, immediatere-education will be performed for staff member. IV. <u>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e. Whatquality assurance program will be put into place:</u> A. _Administrator, or his designee will monitor 3 meals each week to ensure that policy is being followed regarding hand washing and food handling. B. <u>Trends of noncompliance will be reported toQAPI Committee for review and recommendations.</u> V. <u>By what datewill the systemic changes be completed?</u> A. July 15, 2016</p>				

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	<p>At 12:10 p.m., CNA #6 was observed to lather her hands to only 8 seconds prior to rinsing. She was then observed to deliver a meal tray to a resident's room.</p> <p>3. During an observation of the lunch meal in the dining room on 6/13/16, the following was observed:</p> <p>At 12:14 p.m., LPN #8 was observed to lather her hands for 9 seconds prior to rinsing. She then was observed to serve lunch trays to residents seated in the dining room.</p> <p>At 12:15 p.m., LPN #9 was observed to wash her hands for 9 seconds entirely under the running water.</p> <p>At 12:17 p.m., LPN #8 picked up several soiled clothing protectors from the floor in the dining room and placed them in a plastic bag. She then left the dining room.</p> <p>At 12:35 p.m., LPN #8 re-entered the dining room and moved a dining room chair up to a female resident who was yelling out seated at a dining room table. LPN #8 was observed to move the resident's lunch plate around in front of her without washing her hands.</p> <p>At 12:37 p.m., CNA #6 was observed to</p>			

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	<p>push a male resident into the dining room. She was then observed to lather her hands for 7 seconds prior to rinsing. CNA #6 was observed to move the resident's wheelchair up to a dining room table and place a clean clothing protector on him. She then was observed to obtain the resident's meal tray from the kitchen window, take his tray back to his table, and prepare his bowls of food to assist him with his lunch meal.</p> <p>At 12:39 p.m., LPN #8 was observed to obtain a sandwich for the female resident who was yelling out. She was observed to remove the sandwich from the protective bag with her bare hands. She was also observed to lift up the top slice of bread from the sandwich with her bare hands.</p> <p>At 12:41 p.m., LPN #8 was observed to lather her hands 5 seconds prior to rinsing.</p> <p>At 12:44 p.m., LPN #8 was observed to pick up a napkin from the floor. She was observed to use a small amount of sanitizer on her hands. She then was observed to carry a bowl of fruit to a resident seated at a dining room table, remove the plastic covering over the bowl of fruit, and hand him a napkin.</p>			

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F 0520 SS=F Bldg. 00	<p>The Certified Dietary Manager was interviewed on 6/14/16 at 10:09 a.m. During the interview she indicated staff were to lather their hands for 20 seconds out of the running water. She also indicated staff should wash their hands after touching a soiled object or a resident, and before assisting a resident to eat.</p> <p>A current facility policy "Hand Washing Technique", with a revision date of 6/1/15 and provided by the Administrator on 6/14/16 at 11:14 a.m., indicated "...Personnel will wash hands to remove dirt, organic material, and transient microorganisms to prevent the spread of infection...Rub hands together vigorously for 15-20 seconds, generating friction on all surfaces of the hands and fingers..."</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p>						

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	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility's QAPI (Quality Assurance and Performance Improvement) Committee failed to implement and/or revise action plans for the identified concerns to ensure meaningful out of room activities of interest and/or 1 to 1 activities were provided for a dependent resident, a comprehensive care plan was developed for a fluid distribution plan for a fluid restriction ordered by the Physician, physician orders and care plans were followed for Physician ordered renal diet with double portions of meat, a fluid</p>	F 0520	<p>F520 QAA COMMITTEE-MEMBER/MEET/QUARTERLY/PLANS</p> <p>i. <u>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:</u></p> <p>-</p> <p>1. All residents in facility have the potential to be affected by the deficient practice. Corrective actions will be made for all resident's benefit.</p> <p>II. <u>How are other residents having the potential to be affected by the same deficient practice and What corrective actions will be taken:</u></p>	07/15/2016

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	<p>restriction and a diet order for double starch, double vegetables, double fruit, double bread and double dessert, care plan for Restorative Nursing Services was provided to a resident, fresh ice water was passed every shift, hazardous chemicals and personal care products were stored securely away from confused, independently mobile residents; interventions were implemented for significant weight loss, residents' medications were administered to per facility policy with assessments of respiratory status, proper preparation of medication for administration into enteral feeding tube, medications were administered at the correct time and/or with food as ordered, staff appropriately washed their hands during dining services and handled resident's food in a sanitary manner. This deficient practice had the potential to affect 43 of 43 residents who resided at the facility.</p> <p>Findings include:</p> <p>The QAPI (Quality Assurance/Performance Improvement) committee, consisted of the Administrator, the DON (Director of Nursing), ADON (Assistant Director of Nursing), Medical Director, Managers of each of the Facility's Departments, met monthly.</p>		<p>1. Residents residing in the facility have the potential to be affected by the deficient practice.</p> <p>2. The Executive Director and the Department Heads will be re-educated on regulation F520 and the facility's policy regarding quality assurance on or before July 15th by the Executive Director.</p> <p>III. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u></p> <p>-</p> <p>1. The Regional Vice-President of Operations (RVPO)/RDCS will monitor the QAPI monthly for six months to ensure substantial compliance. A member of the regional team will attend two quarterly QAPI committee meetings by conference call or in person to make sure the identified is properly monitored and corrected. The QAPI committee will determine if further action is indicated.</p> <p>1. The QAPI committee will make sure all identified issues are followed by recommendation from the committee and monitored to make sure the plan of corrections are respected. All staff in services will be conducted to educate staff on the plan of correction.</p> <p>2. The ED and the DCS or their designee will verify and educate</p>	

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	An interview with the Administrator and DON on 6/15/16 at 12:40 p.m., indicated the QAPI Committee met monthly and concerns were review by the QAPI Committee. They indicated an action plan was developed for unresolved concerns, the staff was in-serviced about the action plan, the action plan was implemented and monitored for the action plan's effectiveness. They indicated both positive and negative outcomes were reviewed and continued concerns were reviewed for trends and action plans would be revised as needed. The Administrator indicated any concerns affecting the residents were always a high priority to the QAPI Committee. The DON indicated they use QAPI tools to develop action plans. They also indicated the QAPI Committee continued to monitor call lights which were identified as a concern during the last annual survey. The DON indicated the QAPI Committee reviewed infections, falls, pressure ulcer when present, accidents and incidents every month. The Administrator also indicated they review the updates and upkeep of the building environment. The Administrator and DON further indicated the staff were in-serviced on hand washing in the dining room which included demonstrations of proper hand		the respective department on the QAPI recommendations every two weeks for the next one three months and monthly thereafter to be in compliance. IV. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place:</u> 1. All QAPI minutes will be forwarded to the regional office to verify compliance and during visits by the regional for the next three months; the team will verify and sign the compliance of all the identified problems by the QAPI. V. <u>By what date will the systemic changes be completed?</u> A. July 15, 2016 ATTACHMENT A Water Pitcher Procedure: In accordance with Policy and Procedure: N-1222 regarding Water Pitchers (See Back) , and in an effort to ensure that Fresh water will be kept readily available for our residents; the following procedure will be followed related to Water Pitchers: Effective 6-14-16, Non-disposable water pitchers will be used for residents, instead of disposable Styrofoam cups. We will continue to				

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	<p>washing. They also indicated they had identified the concern with hydration and new insulated drink-ware was ordered and recently was implemented. They indicated the concern with activities had been identified and planned to have more activities which also were to include outings for shopping, eating out at restaurant and picnics in the park. They indicated assigned staff make rounds every morning to check for chemicals and personal care products left out and indicated they assisted residents to store securely. The DON indicated new physician orders were reviewed daily and monitored to assure the orders were implemented. The DON also indicated the IDT (Interdisciplinary Team) were responsible to monitor and update the residents care plans. The DON indicated they had identified the need for an additional Restorative Aide to provide the recommended Restorative Plan. She also indicated the Administrator had received approval to hire an additional Restorative Aide to provide Restorative Services everyday of the week. The DON indicated medication administration would be corrected, the nurses would be in-serviced and monitored for accuracy.</p> <p>On 6/15/16 at 2:30 p.m., the current facility's policy provided by the</p>		<p>use disposable straws with the pitchers. Procedure: 3rd Shift CNAs will wash hands and gather clean pitchers from storage area above sink in dining room and place them on the Water Pitcher Cart. CNAs will fill pitchers, using ice scoop with ice, taking care to completely fill each pitcher with ice. Pitchers will then be filled with water and the lids placed on each cup. Disposable straws will be placed in each pitcher, leaving the top section of the straw wrapper over the end of each straw. Once the cart is ready with prepared pitchers of ice water, CNA will utilize cart to take pitchers to residents' rooms. See attached Policy and Procedure (On back) regarding placement. Note: Remove straw wrappers from straws once in resident's rooms CNAs will remove dirty pitchers prior to placing each fresh pitcher. The dirty pitchers will be placed on a separate cart. Once all Fresh Ice Water is passed and all dirty pitchers are gathered both carts are to be placed in the Time Clock Vestibule for cleaning. Cart will be cleaned /sanitized by Dietary staff and returned, covered, to the Time Clock vestibule. Ice water is also to be given to residents upon request throughout the shift. Remember to encourage residents to drink throughout the shift while providing care.</p>	

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	<p>Administrator was reviewed. The policy was titled, Performance Improvement Committee (Quality Assurance) with and effective date of 11/30/14 indicated, "...The Performance Improvement Committee will meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee shall direct all activities including approving proposed monitoring, evaluating and review of services...The committee will assure QAPI (Quality Assurance Performance Improvement) activities have written indicators and standards/thresholds for evaluation, that appropriate actions are implemented, and that such correction has been evaluated by subsequent monitoring...The Performance Improvement Committee will develop and revise the Performance Improvement Calendar annually and as needed to ensure the Performance Improvement Program review and addresses key aspects of care and key indicators using data from multiple sources that evaluate a full range of care and services. This includes but is not limited to the company Performance Indicators....The Committee will assign interdisciplinary performance action teams activities and monitor the team's progress. A Performance Action Team will be developed to collect and evaluate</p>		<p>Note: Half of the water pitchers to be used are pink, and half are gray. In order to ensure that pitchers are switched out each night, a calendar will be placed in the Shower Book (Skin Book) indicating which color will be used each night. For example, if the Calendar states that "Gray" will be used on the 14th, when Night shift comes in on the 14th, the CNAs will use gray cups for the FRESH WATER and pull the pink dirty cups out of the rooms. THE COLOR ON THE CALENDAR REFLECTS THE COLOR NIGHT SHIFT WILL USE FOR FRESH WATER, so if the 14th says "GRAY" we will expect to see GRAY cups in the rooms all day on the 15th.</p> <p>NOTE: These pitchers are purchased for resident use only. We have enough for residents only. They are not available for family members. We will continue to have a small supply of Styrofoam cups available for family members desiring a cup of ice water, but the residents will be given pitchers. This will allow the ice to remain in the cups longer than the Styrofoam, and is in an effort to comply with State Regulations. If residents have questions regarding the new pitchers, please explain this to them.</p> <p>NOTE: WATER CART IS FOR THIS PURPOSE ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE OR HAVE ANYTHING ELSE PLACED ON IT.</p> <p>NOTE: NIGHT SHIFT CNAs ARE</p>				

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	data and to plan and implement needed action under the direction of the Performance Improvement Committee...." 3.1-52(a)(2)		EXPECTED TO WORK TOGETHER TO COMPLETE THIS TASK. DO NOT LOAD CART WITH HALF THE CUPS FOR YOURSIDE ONLY. ALL CUPS ARE TO BE DONE ATONCE. 6-14-16		