

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 26, 27, 28, 29, June 1, 2, and 3, 2015</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Census bed type: SNF: 19 SNF/NF: 107 Residential: 45 Total: 171</p> <p>Census payor type: Medicare: 22 Medicaid: 71 Other: 33 Total: 126</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>R000</p> <p>This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revisions of federal and state law.</p>	
F 0156 SS=A Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p>			

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

TITLE

(X6) DATE

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

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	<p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p>			

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	<p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview,</p>	F 0156	REQUEST DESK COMPLIANCE	06/19/2015

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	<p>the facility failed to ensure Medicare Non-coverage letters were given in a timely manner for 1 of 3 residents reviewed for liability services of the 3 who met the criteria for liability services. (Resident #86)</p> <p>Finding includes:</p> <p>On 6/1/15 at 4:00 p.m., the Medicare Non-coverage letters were reviewed. There was no letter provided for Resident #86.</p> <p>Interview with the Social Service Director on 6/1/15 at 4:00 p.m. indicated no letter had been provided to Resident #86. She further indicated she was unsure if the resident should have received a letter or not.</p> <p>Continued interview with the Social Service Director on 6/2/15 at 10:28 a.m. indicated she had looked into the situation and had found out the resident had received Medicare Part A skilled services for 5 days and had not made it to the list she used to keep track of the residents because the skilled care had already ended by the following week. She further indicated the resident was just missed and never received a letter.</p> <p>3.1-4(a)</p>		<p>F156</p> <p>What correctiveaction(s), will be accomplished for those residents found to have been affectedby the deficient practice.</p> <p>1. Resident# 86 no longer resides in this facility</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken:</p> <p>1. Residentsreceiving services under their Medicare benefits at this facility have the potential to be affected.</p> <p>2. Audit conducted by Business OfficeManager to assure all Medicare non-coverage letters have been served by Social Service.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does no recur.</p> <p>1. ExecutiveDirector /designee will in-service Social Services staff according to the Checklist/instructions for issuinga Notice of Medicare Non-Coverage .</p> <p>2. At daily,Monday-Friday risk management meeting all residents receiving nursing onlyrelated Medicare coverage will be addedto risk management list to assure they are tracked and Medicare non-coverage letter served appropriately.</p>	

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent</p>		<p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur, i.e.,what quality assurance program will be put into place.</p> <p>1. TheSocial Service Director/designee will audit 100% of risk management notes for Medicare recipients for six months toassure Medicare non-coverage letters are served appropriately and timely. Reports of the audits will be discussed at the Quality Assurance committee meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop a plan ofaction to correct and recommend continued monitoringuntil corrections are effective.(See attachment #4)</p>	

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	<p>practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update and revise a care plan for a resident related to falls and fluid restriction for 2 of 14 residents reviewed for care plans. (Resident #157 and #103)</p> <p>Findings include:</p> <p>1. Resident #157's record was reviewed on 5/28/15 at 11:11 a.m. The resident's diagnoses included, but were not limited to, history of falls, vertigo, and hypertension.</p> <p>Review of the Nursing Notes for April 2015 and May 2015, indicated multiple attempts by the resident to self transfer or ambulate without assistance. The Nursing Notes also indicated the resident was non compliant with using the call light, asking for staff assistance, and would turn off the bathroom door alarm at times.</p> <p>Review of a Physician's Progress Note, dated 5/20/15, indicated "...the patient has recurrent falls and though she does have a memory problem she does know she is supposed to ask for help, every fall</p>	F 0280	<p>F280 REQUEST DESKCOMPLIANCE What correctiveaction(s), will be accomplished for those residents found to have been affectedby the deficient practice. 1. The cited comprehensive care plan for 2 of 14 residents has been updated to include thefact that Resident #157 was non-compliant with fall interventions. Resident #103's care plan was updated immediately to indicate the amount of fluid dietary and nursing was to provide daily regarding fluidrestriction. How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken: 1. Residentswithin the facility have the potential to be affected by the same practice. 2. All Careplans of residents with fluid restrictions and recent falls checked indicatedno other residents wereaffected. What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur. 1. Scheduled staff re-education beginning 6/11/15 that MDS is notified immediately</p>	06/19/2015

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	<p>she has a reason why she did not call for help..."</p> <p>Review of a Physician's Progress Note, dated 3/29/15, indicated "...discussed again the risk of falls, patient even has reminder signs up in very large print and in bold to not get up without assistance, she does not want to wait for staff..."</p> <p>Interview with CNA #1 on 6/3/15 at 9:10 a.m. indicated the resident was not always good about using the call light and asking for assistance to use the restroom. She further indicated sometimes the resident would just get up and go to the restroom by herself.</p> <p>Interview with RN #1 on 6/3/15 at 10:05 a.m. indicated she had witnessed the resident on occasion get up and turn off the bathroom door alarm herself. She further indicated there were multiple Nursing Notes of the resident being non compliant.</p> <p>Interview with Restorative Nurse #1 on 6/3/15 at 11:06 a.m. indicated the resident was very non compliant with fall interventions. She further indicated the non compliance was documented in the Nursing Notes but was not care planned.</p> <p>Resident #157 had a care plan, dated</p>		<p>of any updates for all care plan as it relates to falls and fluid restriction as well as proper documentation for accuracy. 2. Restorative nurse re-education related to update of all care plan for interventions to prevent future falls as well as any noncompliance noted related to interventions put in place following the fall. 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.</p> <p>1. The DON/designee will audit 100% of all residents with fluid restriction and all fall interventions daily at morning meeting five days a week for six months. Reports of these audits will be discussed and given to Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective. (see attachment #5)</p>	

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	<p>12/15/14, for high risk for falls related to unaware of safety needs, diagnosis of dementia and vertigo, history of falls, and takes psychotropic medication.</p> <p>The care plan lacked documentation of the resident's non compliance with fall interventions.</p> <p>Interview with the DON (Director of Nursing) on 6/3/15 at 11:33 a.m. indicated the resident's non compliance should have been care planned.</p> <p>2. Resident #103's record was reviewed on 5/27/15 at 2:35 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, congestive heart failure, and hypertension.</p> <p>Interview with Resident #103 on 6/1/15 at 9:08 a.m. indicated she was on a fluid restriction and the staff kept track of the fluid amounts for her. She indicated she was only to have a certain amount with meals and also with her medications.</p> <p>Review of the Annual Nutritional Assessment, dated 11/5/14, indicated the resident was on a 2000 cubic centimeters (cc) fluid restriction daily. There was lack of documentation to indicate the amount of fluid dietary and nursing was to provide daily.</p>				

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	<p>Review of the CNA Care Card, received from the B Hall Nurse as current, indicated the resident was on a 2000 cc fluid restriction. There was lack of documentation to indicate the amount of fluid dietary and nursing was to provide daily</p> <p>Review of the Treatment Administration Record (TAR) for June 2015 indicated the resident was on a 2000 cc fluid restriction. The fluid restriction was checked off by the staff every shift but no fluid amounts were charted. There was lack of documentation to indicate the amount of fluid dietary and nursing was to provide daily</p> <p>Resident #103 had a care plan for congestive heart failure, morbid obesity, therapeutic diet, and 2000 cc fluid restriction every 24 hours. The Nursing interventions included "2000 fluid restriction."</p> <p>The care plan lacked documentation to indicate the amount of fluid dietary and nursing was to provide daily.</p> <p>Interview with LPN #6 on 6/3/15 at 9:20 a.m. indicated the resident was on a fluid restriction and nursing was responsible for so much. She indicated there used to</p>			

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F 0282 SS=D Bldg. 00	<p>be a sheet in the resident's hard chart that indicated how much was to be given by nursing and dietary but she was unsure of where that information would be now. She further indicated staff did not keep track of I&O (intake and output) or anything like that.</p> <p>Continued interview with LPN #6 on 6/3/15 at 9:55 a.m. indicated each meal ticket had the amount of fluids the resident was to receive with each meal and nursing was allowed around 500 cc for med pass.</p> <p>3.1-35(d)(2)(B)</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. Based on observation, record review, and interview, the facility failed to ensure the current plan of care was followed as written related to medications not given according to Physician orders and dialysis assessments not completed for 1 of 1 residents reviewed for Dialysis of the 1 who met the criteria for Dialysis and fall interventions not in place for 1 of 3 residents reviewed for Accidents of the</p>	F 0282	<p>REQUEST DESK COMPLIANCE F282 What correctiveaction(s), will be accomplished for those residents found to have been affectedby the deficient practice. 1. The cited plan of care updated to include the fact that Resident #157 was non-compliant with fall interventions. 2. Resident#101's physician was notified related to</p>	06/19/2015

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	<p>10 who met the criteria for Accidents. (Resident's #101 and #157)</p> <p>Findings include:</p> <p>1. Record review for Resident #101 was completed on 5/28/15 at 11:03 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, diabetes type II and hypertension.</p> <p>Review of the May 2015 POS (Physician Order Summary) indicated an order for Benadryl (antihistamine) 25 mg (milligrams) to give 2 tablets as needed for inability to sleep ("DO NOT GIVE BENADRYL PRIOR TO DIALYSIS") may give QHS (every night) PRN (when necessary). The POS also indicated an order for Norco (narcotic pain medication) 7.5-325 mg to give 1 tablet every 8 hours as needed for moderate to severe pain ("DO NOT GIVE PRIOR TO DIALYSIS GIVE ONLY TYLENOL IF NEEDED PRIOR TO DIALYSIS").</p> <p>Review of the May 2015 MAR (Medication Administration Record) indicated the resident received both the Benadryl and Norco prior to dialysis on the following dates:</p> <p>Benadryl: 5/1/15 at 8:15 a.m.</p>		<p>non-compliance of medication prior to dialysis. Re-education and counseling with staff nurses who were giving care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: 1. Residents within the facility have the potential to be affected by the same practice. 2. All Physician orders related to residents on dialysis, care plans of residents with dialysis and recent falls checked indicated; no other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. 1. Scheduled staff re-education beginning 6/11/15 that MDS is notified immediately of any updates for all care plan as it relates to falls and fluid restriction as well as proper documentation for accuracy related to physician orders for dialysis residents 2. Restorative nurse re-education related to update of care plan for interventions to prevent future falls as well as any noncompliance noted related to interventions put in place following the fall. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>	

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	<p>5/4/15 at 8:15 a.m. 5/6/15 at 8:09 a.m. 5/8/15 at 8:14 a.m. 5/11/15 at 8:38 a.m. 5/13/15 at 7:49 a.m. 5/15/15 at 8:15 a.m. 5/18/15 at 8:14 a.m. 5/20/15 at 8:21 a.m. 5/25/15 at 8:16 a.m.</p> <p>Norco: 5/4/15 at 8:15 a.m. 5/6/15 at 8:10 a.m. 5/8/15 at 8:15 a.m. 5/11/15 at 8:35 a.m. 5/13/15 at 7:50 a.m. 5/15/15 at 8:15 a.m. 5/18/15 at 8:14 a.m. 5/20/15 at 8:22 a.m.</p> <p>A Care Plan dated 11/13/14 indicated: Resident received dialysis for diagnosis of end stage renal disease. Interventions included: Monitor/document/report to Physician when necessary any signs or symptoms of renal insufficiency.</p> <p>Review of Dialysis Communication Forms and Nursing Notes from April 3, 2015 to May 25, 2015, indicated a prior assessment before dialysis was not completed for Resident #101 on the following dates:</p>		<p>program will be put into place. 1. TheDON/designee will audit 100% of residents with fluid restriction and non-compliance with fall interventionsdaily at morning meeting five days a week for six months. All Physician orders related to resident on dialysis will also be audited at the same time. Reports of these audits will be discussed and given to Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality AssuranceCommittee will develop plans of action to correct and recommend continued monitoring until corrections areeffective.(See attachment #5)</p>		

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	<p>4/3/15 5/11/15 5/20/15 5/25/15</p> <p>Interview with LPN #5 on 5/28/15 at 2:04 p.m., indicated the resident was alert and oriented and would request the Benadryl and Norco before going to dialysis.</p> <p>Interview with the DON (Director Of Nursing) on 6/3/15 at 9:00 a.m., indicated the Physician was notified, the Benadryl was discontinued and the Norco was not to be given before dialysis. She further indicated nursing should have notified the Physician when the resident would request the Benadryl and Norco before dialysis.</p> <p>Interview with the DON on 6/2/15 at 2:38 p.m., indicated staff should have completed an assessment including vital signs before the resident went to dialysis.</p> <p>2. On 6/3/15 at 9:13 a.m. Resident #157 was observed lying in bed with her eyes closed. One call light button was observed behind the pillow she was lying on, out of reach. A second call light button with red tape on it was observed on the floor behind the head of the bed, out of reach. The bathroom door was observed to be open and the bathroom</p>				

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	<p>door alarm switch was in the off position. The resident's bed controller was observed to be hanging from the side rail, in reach of the resident.</p> <p>On 6/3/15 at 10:00 a.m. Resident #157 was observed awake, lying in bed watching television. One call light button was observed behind the pillow she was lying on, out of reach. A second call light button with red tape on it was observed on the floor behind the head of the bed, out of reach. The resident indicated she would use the call light if she was able to reach one. The bathroom door was observed to be open and the bathroom door alarm switch was in the off position. The resident indicated she preferred the alarm to be turned off. The resident's bed controller was observed to be hanging from the side rail, in reach of the resident.</p> <p>Resident #157's record was reviewed on 5/28/15 at 11:11 a.m. The resident's diagnoses included, but were not limited to, history of falls, vertigo, and hypertension.</p> <p>Review of the CNA Care Card, received from the C Hall Nurse as current, indicated the resident was ah high fall risk, had a bathroom door alarm and colored call light cord.</p>			

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	<p>Resident #157 had a care plan, dated 12/15/14, for high risk for falls related to unaware of safety needs, diagnosis of dementia and vertigo, history of falls, and takes psychotropic medication. The Nursing interventions included, "...keep bed controller out of reach...call light reminder signs and colored call light cord...bathroom door alarm...a working and reachable call light..."</p> <p>Interview with CNA #1 on 6/3/15 at 9:10 a.m. indicated the resident was not always good about using the call light and asking for assistance to use the restroom. She further indicated sometimes the resident would just get up and go to the restroom by herself.</p> <p>Interview with RN #1 on 6/3/15 at 10:05 a.m. indicated the bathroom door alarm should have been on, the bed controller should have been out of reach, and the call light should have been in reach of the resident. She further indicated she had witnessed the resident on occasion get up and turn off the bathroom door alarm herself. She indicated she was unsure why the resident had two different call light buttons but figured it must have been done on purpose because there was a split call light cord connected to the wall. She checked both call light buttons</p>			

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F 0309 SS=D Bldg. 00	<p>and both functioned. She further indicated there were multiple Nursing Notes of the resident being non compliant.</p> <p>Interview with Restorative Nurse #1 on 6/3/15 at 11:06 a.m. indicated the resident was very non compliant with fall interventions. She further indicated the non compliance was documented in the Nursing Notes but was not care planned. She further indicated she was not aware the resident had two call light buttons and she was not sure why.</p> <p>Interview with Restorative Nurse #1 on 6/3/15 at 12:24 p.m. indicated she had spoken to the CNA working this morning and she had checked the resident's door alarm this morning around 6:00 a.m. and it was in place and working but the CNA had not charted for today yet. She further indicated the alarm was also checked on the midnight shift and was in place and working.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>			

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to medications not given according to Physician orders and dialysis assessments not completed for 1 of 1 residents reviewed for Dialysis of the 1 who met the criteria for Dialysis and intake not being monitored for a resident on fluid restrictions for 1 of 1 residents reviewed for Hydration of the 1 who met the criteria for Hydration. (Resident's #101 and #103)</p> <p>Findings include:</p> <p>1. Record review for Resident #101 was completed on 5/28/15 at 11:03 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, diabetes type II and hypertension.</p> <p>The Quarterly MDS (Minimum Data Set) assessment completed on 5/21/15 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 15 which indicated the resident was cognitively intact. The assessment indicated the resident received dialysis.</p> <p>Review of a Physician Order Sheet dated</p>	F 0309	<p>REQUEST DESK COMPLIANCE SURVEYCOMPLETED 6/3/15</p> <p>F309</p> <p>What correctiveaction(s), will be accomplished for those residents found to have been affectedby the deficient practice.</p> <ol style="list-style-type: none"> 1. Resident#101's physician was notified related to non-compliance of medication prior todialysis. 2. Re-educationand counseling with nursing staff related to following physician's ordersregarding medicationadministration and completion of assessment prior to leaving or dialysis. 3. Dietarysecured information for the floor nurse immediately on 6/3/15 regarding fluid restriction for Resident #103 as it relates toamount floor administers and that which comes fromdietary. Re-education of nurses relatedto documenting fluid restrictions. <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken:</p> <ol style="list-style-type: none"> 1. Residentswithin the facility have the potential to be affected by non- compliancewith 	06/19/2015

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	<p>2/16/15, indicated: No Benadryl (antihistamine) prior to dialysis and please give Tylenol instead of Norco (narcotic pain medication) prior to dialysis - difficult to pull fluid when BP (blood pressure) is low.</p> <p>Review of the May 2015 POS (Physician Order Summary) indicated an order for Benadryl 25 mg (milligrams) to give 2 tablets as needed for inability to sleep ("DO NOT GIVE BENADRYL PRIOR TO DIALYSIS") may give QHS (every night) PRN (when necessary). The POS also indicated an order for Norco 7.5-325 mg to give 1 tablet every 8 hours as needed for moderate to severe pain ("DO NOT GIVE PRIOR TO DIALYSIS GIVE ONLY TYLENOL IF NEEDED PRIOR TO DIALYSIS").</p> <p>Review of the May 2015 MAR (Medication Administration Record) indicated the resident received both the Benadryl and Norco prior to dialysis on the following dates:</p> <p>Benadryl: 5/1/15 at 8:15 a.m. 5/4/15 at 8:15 a.m. 5/6/15 at 8:09 a.m. 5/8/15 at 8:14 a.m. 5/11/15 at 8:38 a.m. 5/13/15 at 7:49 a.m.</p>		<p>physician's orders.</p> <p>2. POC(Plan of Care) will be reviewed daily by midnight shift to assure documentation related to fluid restriction is complete as well as the amount of fluid the floor gives and dietary is present.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>1. Scheduled staff re-education beginning 6/11/15 by DON/designee related to following physician orders and proper fluid restriction documentation.</p> <p>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.</p> <p>1. The DON/designee will audit 100% of residents with fluid restriction daily at morning meeting five days a week for six months. Monitor 100% of residents on dialysis the day after the run to assure physician orders have been given correctly for six months. Reports of these audits will be discussed and given to Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until corrections are effective. (see attachment #5)</p>	

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	<p>5/15/15 at 8:15 a.m. 5/18/15 at 8:14 a.m. 5/20/15 at 8:21 a.m. 5/25/15 at 8:16 a.m.</p> <p>Norco: 5/4/15 at 8:15 a.m. 5/6/15 at 8:10 a.m. 5/8/15 at 8:15 a.m. 5/11/15 at 8:35 a.m. 5/13/15 at 7:50 a.m. 5/15/15 at 8:15 a.m. 5/18/15 at 8:14 a.m. 5/20/15 at 8:22 a.m.</p> <p>A Care Plan dated 11/13/14 indicated: Resident received dialysis for diagnosis of end stage renal disease. Interventions included: Monitor/document/report to Physician when necessary any signs or symptoms of renal insufficiency.</p> <p>Review of Dialysis Communication Forms and Nursing Notes from April 3, 2015 to May 25, 2015, indicated a prior assessment before dialysis was not completed for Resident #101 on the following dates:</p> <p>4/3/15 5/11/15 5/20/15 5/25/15</p>			

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	<p>Interview with LPN #5 on 5/28/15 at 2:04 p.m., indicated the resident was alert and oriented and would request the Benadryl and Norco before going to dialysis.</p> <p>Interview with the DON (Director Of Nursing) on 6/3/15 at 9:00 a.m., indicated the Physician was notified, the Benadryl was discontinued and the Norco was not to be given before dialysis. She further indicated nursing should have notified the Physician when the resident would request the Benadryl and Norco before dialysis.</p> <p>Interview with the DON on 6/2/15 at 2:38 p.m., indicated staff should have completed an assessment including vital signs before the resident went to dialysis.</p> <p>A policy titled, "Dialysis Communication," was received as current from the DON on 6/2/15 at 11:05 a.m. The policy indicated, "...Procedures: 1. A licensed nurse will complete the Communication Form for Outpatient Dialysis prior to the resident going to the dialysis center. Items to be completed are resident, date, dialysis center, resident's weight per facility, blood pressure, temperature, pulse, respirations and nurse's signature...."</p> <p>2. On 6/1/15 at 12:30 p.m. Resident</p>			

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	<p>#103 was observed eating her lunch meal in her room. There was one 8 ounce empty glass observed on her tray. There was a Styrofoam cup full of ice next to the resident's tray on the bedside table. The meal ticket on the resident's tray indicated she was to have 500 cubic centimeters (cc) of fluid with the meal.</p> <p>Resident #103's record was reviewed on 5/27/15 at 2:35 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, congestive heart failure, and hypertension.</p> <p>Interview with Resident #103 on 6/1/15 at 9:08 a.m. indicated she was on a fluid restriction and the staff kept track of the fluid amounts for her. She indicated she was only to have a certain amount with meals and also with her medications.</p> <p>Review of the Annual Nutritional Assessment, dated 11/5/14, indicated the resident was on a 2000 cc fluid restriction daily. There was lack of documentation to indicate the amount of fluid dietary and nursing was to provide daily.</p> <p>Review of the CNA Care Card, received from the B Hall Nurse as current, indicated the resident was on a 2000 cc fluid restriction. There was lack of documentation to indicate the amount of</p>			

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	<p>fluid dietary and nursing was to provide daily</p> <p>Review of the May 2015 Physician Order Summary indicated an order for 2000 cc fluid restriction related to congestive heart failure.</p> <p>Review of the Treatment Administration Record (TAR) for May 2015 indicated the resident was on a 2000 cc fluid restriction. The fluid restriction was checked off by the staff every shift but no fluid amounts were charted. There was lack of documentation to indicate the amount of fluid dietary and nursing was to provide daily</p> <p>Interview with LPN #6 on 6/3/15 at 9:20 a.m. indicated the resident was on a fluid restriction and nursing is responsible for so much. She indicated there used to be a sheet in the resident's hard chart that indicated how much was to be given by nursing and dietary but she was unsure of where that information would be now. She further indicated staff did not keep track on I&O (intake and output) or anything like that.</p> <p>Continued interview with LPN #6 on 6/3/15 at 9:55 a.m. indicated each meal ticket had the amount of fluids the resident was to receive with each meal</p>						

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F 0323 SS=D Bldg. 00	<p>and nursing was allowed around 500 cc for med pass.</p> <p>A facility policy titled "Fluid Restrictions (Process for)", dated 9/29/01, and received as current from the DON, indicated, "...6. Dietary Manager plans the pattern for fluids provided with meals and fluids provided by nursing with med pass. 7. The patterns are placed in the chart in nutrition section, in the MAR, at the nurses' station desk, and a copy is given to the care plan coordinator to add to the care plan...9. Nursing maintains intake records for fluids."</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place and determine root cause of falls for 1 of 3 residents reviewed for accidents of the 10 residents who met the criteria for accidents. (Resident #157)</p>	F 0323	<p>REQUEST DESK COMPLIANCE SURVEY COMPLETED 6/3/15 F323 What corrective action(s), will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident #157's care plan, care plan and nurses notes reviewed by IDT team to assure that all fall interventions are the</p>	06/19/2015

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	<p>Finding includes:</p> <p>On 6/3/15 at 9:13 a.m. Resident #157 was observed lying in bed with her eyes closed. One call light button was observed behind the pillow she was lying on, out of reach. A second call light button with red tape on it was observed on the floor behind the head of the bed, out of reach. The bathroom door was observed to be open and the bathroom door alarm switch was in the off position. The resident's bed controller was observed to be hanging from the side rail, in reach of the resident.</p> <p>On 6/3/15 at 9:32 a.m. Resident #157 was observed lying in bed with her eyes closed. One call light button was observed behind the pillow she was lying on, out of reach. A second call light button with red tape on it was observed on the floor behind the head of the bed, out of reach. The bathroom door was observed to be open and the bathroom door alarm switch was in the off position. The resident's bed controller was observed to be hanging from the side rail, in reach of the resident.</p> <p>On 6/3/15 at 10:00 a.m. Resident #157 was observed awake, lying in bed watching television. One call light button was observed behind the pillow</p>		<p>same in every area and that history of non-compliance related to fall interventions noted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: 1. Residents within the facility with history of falls and/or at high risk for falls have the potential to be affected. IDT team will assess resident to determine that there is correlation between care plan, care cards and documentation. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. 1. Scheduled staff re-education beginning 6/11/15 by DON/designee related to following fall interventions and that the interventions are in place and if the resident is compliant. 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. 1. The DON/designee will monitor/audit during routine rounds to ensure that continued compliance is obtained. 2. The Monitoring will be done daily, Monday through Friday for one month on each nursing unit, and then two times per week for two months and then once weekly for the remaining three months.</p>	

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	<p>she was lying on, out of reach. A second call light button with red tape on it was observed on the floor behind the head of the bed, out of reach. The resident indicated she would use the call light if she was able to reach one. The bathroom door was observed to be open and the bathroom door alarm switch was in the off position. The resident indicated she preferred the alarm to be turned off. The resident's bed controller was observed to be hanging from the side rail, in reach of the resident.</p> <p>Resident #157's record was reviewed on 5/28/15 at 11:11 a.m. The resident's diagnoses included, but were not limited to, history of falls, vertigo, and hypertension.</p> <p>Review of the CNA Care Card, received from the C Hall Nurse as current, indicated the resident was a high fall risk, had a bathroom door alarm and colored call light cord.</p> <p>Resident #157 had a care plan, dated 12/15/14, for high risk for falls related to unaware of safety needs, diagnosis of dementia and vertigo, history of falls, and takes psychotropic medication. The Nursing interventions included, "...keep bed controller out of reach...call light reminder signs and colored call light</p>		<p>(See attachment #5) For resident #157 a special audit will be conducted according to above schedule by all shifts for total of six months (See attachment 5a) 3. The Monitoring/audits will be submitted to the Quality Assurance Committee monthly to assure continued compliance with staff knowledge and competency of the policy as it relates to fall intervention compliance. 4. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop an action plan to correct and recommend continued monitoring until corrections are effective.</p>	

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	<p>cord...bathroom door alarm...a working and reachable call light..."</p> <p>Review of a fall investigation dated 12/29/14 indicated the resident had a fall. The root cause was determined to be ambulating without assistance.</p> <p>Review of a fall investigation dated 1/2/15 indicated the resident had a fall. The root cause was determined to be a failed self transfer.</p> <p>Review of a fall investigation dated 3/6/15 indicated the resident had a fall. The root cause was determined to be a failed self transfer.</p> <p>Review of a fall investigation dated 3/20/15 indicated the resident had a fall. The root cause was determined to be ambulating without assistance.</p> <p>Review of a fall investigation dated 3/31/15 indicated the resident had a fall. The root cause was determined to be a failed self transfer.</p> <p>Review of a fall investigation dated 4/6/15 indicated the resident had a fall. The root cause was determined to be ambulating without assistance.</p> <p>Review of a fall investigation dated</p>			

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	<p>4/14/15 indicated the resident had a fall. The root cause was determined to be a failed self transfer.</p> <p>Review of a fall investigation dated 5/20/15 indicated the resident had a fall. The root cause was determined to be ambulating without assistance.</p> <p>Review of a fall investigation dated 5/25/15 indicated the resident had a fall. The root cause was determined to be a failed self transfer.</p> <p>There was a lack of investigation to determine the root cause of why the resident was self transferring, ambulating without assistance, and non compliant with fall interventions.</p> <p>Interview with CNA #1 on 6/3/15 at 9:10 a.m. indicated the resident was not always good about using the call light and asking for assistance to use the restroom. She further indicated sometimes the resident would just get up and go to the restroom by herself.</p> <p>Interview with RN #1 on 6/3/15 at 10:05 a.m. indicated the bathroom door alarm should have been on, the bed controller should have been out of reach, and the call light should have been in reach of the resident. She further indicated she had</p>			

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	<p>witnessed the resident on occasion get up and turn off the bathroom door alarm herself. She indicated she was unsure why the resident had two different call light buttons but figured it must have been done on purpose because there was a split call light cord connected to the wall. She checked both call light buttons and both functioned. She further indicated there were multiple Nursing Notes of the resident being non compliant.</p> <p>Interview with Restorative Nurse #1 on 6/3/15 at 11:06 a.m. indicated the resident was very non compliant with fall interventions. She further indicated the non compliance was documented in the Nursing Notes but was not care planned. She further indicated she was not aware the resident had two call light buttons and she was not sure why.</p> <p>Interview with Restorative Nurse #1 on 6/3/15 at 12:24 p.m. indicated she had spoken to the CNA working this morning and she had checked the resident's door alarm this morning around 6:00 a.m. and it was in place and working but the CNA had not charted for today yet. She further indicated the alarm was also checked on the midnight shift and was in place and working.</p>			

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F 0329 SS=D Bldg. 00	<p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a gradual dose reduction was attempted for a resident who was receiving an anti psychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #18)</p> <p>Finding includes:</p>	F 0329	<p>REQUEST FOR DESK COMPLIANCE F 329</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. Upon receipt of 2567, Resident #18 was re-assessed for factors that contribute to problematic behaviors and need for anti-psychotic.</p>	06/19/2015	

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	<p>The record for Resident #18 was reviewed on 5/27/15 at 2:42 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance and anxiety disorder.</p> <p>The May 2015 Physician's Order Summary (POS), indicated the resident received Seroquel (an anti psychotic medication) 25 milligrams (mg) by mouth at bedtime (hs).</p> <p>A Pharmacy recommendation dated 1/31/15, indicated the following:</p> <p>"(Resident's name) has been receiving Quetiapine (Seroquel) 25 mg hs since 6/2014. Dose reduction attempts should be made for antipsychotic medications at least twice per year to ensure drug effectiveness with minimal side effects. Recommend evaluating for a dosage reduction to 12.5 mg hs."</p> <p>The recommendation was refused by the Psychiatric Nurse Practitioner on 2/10/15 based on the following: "resident is being treated for a UTI (urinary tract infection) presently. At this time a reduction in Seroquel is clinically contraindicated and may impair her daily functioning.</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Residents currently receiving Anti-psychotic medication have the potential to be affected.</p> <p>b. Resident #18 receiving Anti-psychotic medication will be re-evaluated for of the need for the medication by June 11, 2015.</p> <p>What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur:</p> <p>a. Social Service, unit manager, as well as psychiatric services will confer with clinical pharmacist for evaluation of gradual dose reduction for any resident receiving and/or being considered for use anti-psychotic medication. The evaluation by social service, unit manager and pharmacist will be based on the gradual dose reduction per federal regulations.</p> <p>(See attachment #6)</p> <p>b. On 6/11/15 Social service director met with Psychiatric service Nurse Practitioner to review present gradual dose reduction regulation.</p> <p>How the corrective action(s) will be monitor to ensure the deficient practice will not recur:</p> <p>a. Social Service/designee will monitor/audit Monday thru Friday</p>	

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	<p>The 2/10/15 Psychiatric progress note indicated the resident was calm and cooperative. There were no reports of behavior disturbances since the December GDR (gradual dose reduction) of Trazodone (an anti depressant). Seroquel 25 mg every hs. Resident started treatment for a UTI on 2/6/15. Macrobid (an antibiotic) 100 mg twice a day for 7 days. At this time, it is clinically contraindicated to reduce Seroquel. It may impair her daily functioning. Will continue to monitor behavior, condition, and manage medication as clinically indicated.</p> <p>The 3/4/15 Behavior assessment indicated the resident had no recent behaviors.</p> <p>The 3/17/15 Quarterly Minimum Data Set (MDS) assessment, indicated the resident had no mood or behavior issues.</p> <p>Interview with the Social Service Director on 6/2/15 at 1:55 p.m., indicated the rationale for the refusal of the Seroquel GDR should have been based on the resident's behaviors rather than based on the resident receiving an antibiotic at the time of the recommendation.</p> <p>3.1-48(a)(3)</p>		<p>records of residents exhibiting behaviors or on anti-psychotic medication to ensure that continued compliance is obtained.</p> <p>b. Monitoring/audit will be done daily Monday thru Friday on each nursing unit by social service personnel. (See attachment #7)</p> <p>c. The monitoring/audits will be submitted to the Quality Assurance Committee and continue to be conducted monthly to assure continued compliance with staff knowledge and competency of the policies until the compliance is maintained as determined by the Quarterly Assurance Committee review.</p>				

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F 0356 SS=B Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the daily staffing pattern was posted</p>	F 0356	<p>REQUEST FOR DESK COMPLIANCE F 356</p> <p>What corrective action(s) will be accomplished for those</p>	06/19/2015

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	<p>throughout the facility.</p> <p>Finding includes:</p> <p>On 6/1/15 at 9:25 a.m., 10:15 a.m., 12:48 p.m., and 3:08 p.m., the daily staffing sheet, which was posted at the Main Entrance, was dated 5/29/15. There was no staffing sheet posted at the Lower Level entrance to the facility.</p> <p>On 6/2/15 at 10:06 a.m., 1:15 p.m., and 1:50 p.m., the daily staffing sheet, which was posted at the Main Entrance, was dated 5/29/15. Again, there was no staffing sheet posted at the Lower Level entrance.</p> <p>Interview with the Director of Nursing on 6/2/15 at 1:55 p.m., indicated the staffing sheet was dated 5/29/15 and it needed to be changed.</p> <p>Interview with the Administrator on 6/3/15 at 2:55 p.m., indicated a staffing sheet should have been posted at the Lower Level entrance to the facility.</p>		<p>residents found to have been affected by the deficient practice:</p> <p>a. Nursing staffing data sheet updated immediately.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. The deficient practice has potential to affect all residents within facility.</p> <p>What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur:</p> <p>a. Staffing coordinator re-inserviced 6/3/15 regarding requirement related to accurate daily staffing sheets being posted.</p> <p>b. Nursing management re-educated on the requirement of posting accurate daily staffing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>a. Administrator/designee will conduct audits daily for two months, then three times weekly for four months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until compliance is maintained.</p> <p>(See attachment #8)</p>		

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F 0364 SS=D Bldg. 00	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to serve food at a warm temperature for 1 of 2 meals observed on 1 of 3 units. (Resident #103)</p> <p>Finding includes:</p> <p>an interview with Resident #103 on 5/26/15 at 4:07 p.m., indicated she ate all meals in her room. The resident further indicated the food was frequently not warm enough when it was served to her.</p> <p>On 6/1/15 at 12:10 p.m., the Eden Unit cart of lunch trays was brought to the unit. At that time, some of the trays were passed on B Hall. At 12:15 p. m. the cart was taken down C Hall and trays were delivered. At 12:23 p.m. the cart was taken down D Hall and trays were</p>	F 0364	<p>REQUEST FOR DESK COMPLIANCE F 364 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. All room trays served are palatable, attractive and at proper temperature. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. The deficient practice has potential to affect all residents within facility. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: a. Nursing and dietary staff will distribute room trays from the steam table two at a time to assure that the meals are palatable and proper</p>	06/19/2015

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F 0441 SS=D Bldg. 00	<p>delivered.</p> <p>The last tray was passed at 12:25 p.m. At that time, temperatures were taken of the food on the test tray that had been placed on the cart and delivered with the residents' trays. The pulled pork sandwich was 140 degrees Fahrenheit (F), the french fries were 102 F, and the corn was 102 F.</p> <p>Interview with Dietary #1 on 6/1/15 at 12:29 p.m. indicated she was unsure of what the food temperatures should have been when served to the residents. She further indicated she would have to go look it up.</p> <p>A facility policy titled "Monitoring Food Temperatures for Meal Service", undated, and received as current from the Dietary Manager, indicated, "...7...Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 F or greater to promote palatability for the resident..."</p> <p>3.1-21(a)(2)</p>		<p>temperature. How the corrective action(s) will be monitor to ensure the deficientpractice will not recur: a. Dietary supervisor/designee will conduct audits three times weekly testing trays each meal for six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until compliance is maintained. (Seeattachment #9)</p>		
	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS				

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	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained related to improper</p>	F 0441	<p>WE REQUEST DESK COMPLIANCE</p> <p>F 441</p> <p>1.What corrective action (s) will</p>	06/19/2015

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	<p>disposal of a glucometer test strip (a test strip used to test blood sugars) and lack of glove use by staff during insulin administration. This had the potential to affect 10 residents that received glucometer testing and 7 residents that received insulin injections on the C Hall. (C Hall) (Resident #24)</p> <p>Findings include:</p> <p>During observation of Resident #24's glucometer testing (testing of blood for blood sugars) on 5/28/15 at 10:28 a.m., RN #1 donned gloves, cleaned the resident's right 4th finger with an alcohol wipe, pricked the resident's finger with a lancet, then placed a drop of blood on the test strip. After the blood sugar reading was received, RN #1 removed her gloves with the used test strip in the gloves and threw the gloves into the resident's garbage can. RN #1 then washed her hands and proceeded to draw up the resident's insulin into a syringe. RN #1 cleaned the resident's left lower abdomen with an alcohol wipe and then administered the insulin. The nurse did not wear gloves during the insulin administration.</p> <p>Interview with RN #1 during the observation indicated she should have thrown the used test strip into a sharps</p>		<p>be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1. Resident #24 had no adverse consequences from the handling of the used glucose strip or the administration of insulin without gloves.</p> <p>1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. Residents with glucose testing and insulin administration have the potential to be affected by this practice.</p> <p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. Re-educate nursing staff related to:</p> <p>1. Placing used glucose monitoring strips into sharps container</p> <p>B Wearing gloves for all injections according to facility policy.</p> <p>1. 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.</p>		

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F 0463 SS=D Bldg. 00	<p>container and not the garbage can. She further indicated she did not like to wear gloves when giving insulin injections.</p> <p>Interview with the DON (Director of Nursing) on 5/28/15 at 11:28 a.m., indicated the nurse should have thrown the used test strip into a sharps container and not the garbage can. She further indicated the nurse should have worn gloves while administering the injection.</p> <p>A policy titled, "Specific Medication Administration Procedures" was received as current from the DON on 5/28/15 at 11:28 a.m. The policy indicated, "...Injectable Medication Administration...Equipment Required: E. Examination gloves...Procedure: Put on gloves...."</p> <p>3.1-18(a)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure residents were provided a functioning call system device</p>	F 0463	<p>1.Compliance nurse/designee will audit forplacement of used glucose strips into sharps container and wearing gloves forall injections. Audit will involveobservation of one glucose monitoring and one injection per unit, three timesper week, different shifts for two weeks, then two times per week for twomonths, then one time per week for two months, then every other week for two weeks. Reports of the audits will be reported to theQA meeting monthly for six months.(See attachment #10)</p> <p>Request Desk Review F 463 What correctiveaction(s) will be accomplished for those residents</p>	06/19/2015

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	<p>in the bathroom for 1 of 40 residents whose call lights were observed. (Resident #189)</p> <p>Finding includes:</p> <p>On 5/27/15 at 9:20 a.m., an observation was made in Room 251 with Resident #189. When the call button was pressed in the resident's bathroom the light failed to illuminate in the hall.</p> <p>Interview with CNA #2 on 5/27/15 at 9:29 a.m., indicated staff were aware Resident #189's bathroom call light did not work and a work order had been put in to maintenance a few days prior.</p> <p>Interview with LPN #7 on 5/27/15 at 9:33 a.m., indicated staff were aware Resident #189's bathroom call light did not work and a work order had been put in to maintenance a few days prior. She further indicated staff were to stay in the bathroom with the resident until the call light was fixed.</p> <p>Interview with the Maintenance Manager on 5/27/15 at 9:38 a.m., indicated he was not aware Resident #189's bathroom call light did not work and staff should have told him. He further indicated he had not received any work orders for Resident #189's bathroom call light not working.</p>		<p>found to have been affected by the deficient practice?</p> <p>1. Nurse call light for resident #189 was found to have burned out bulb, replaced and light now functioning.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. No residents were adversely affected by the deficit.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>1.. Staff re-educated related to completion of work orders for any new area of concerns like those listed above .</p> <p>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.</p> <p>1. Housekeeping staff will audit the identified rooms two times a week for two weeks, then 10% of the rooms on each nursing unit once a week for two months, then every other week for two months and then every three weeks for two months, all audits will total six months.</p> <p>b. Deficits identified will be submitted to the maintenance supervisor for repair when identified by housekeeping supervisor completing work order.</p> <p>c. Audits will be submitted to</p>	

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F 0465 SS=E Bldg. 00	<p>He indicated a house audit on call lights was completed every other month and 5 random rooms were completed weekly. The Maintenance Manager checked the light bulb in the call system in the hall and replaced the bulb. The bathroom call light was tested again and the light illuminated in the hall.</p> <p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain an environment that was safe, clean, and in a state of good repair, related to marred/gouged walls, paint chipped and peeling from the walls, door frames and ceiling, chipped floor tiles in a bathroom and a toilet paper dispenser broken for 3 of 3 units throughout the facility. (Reclaim Unit, Haven Unit and Eden Unit)</p> <p>Findings include:</p> <p>During the Environmental tour on 6/3/15 at 9:50 a.m., - 10:25 a.m., with the Maintenance Manager and the</p>	F 0465	<p>the Quality Assurance Committee and continue to be conducted for six months to assure continued compliance.</p> <p>REQUEST DESK COMPLIANCE F 465 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ol style="list-style-type: none"> 1. Wall between bathroom and shelf in room 262-A repaired 2. Plaster on ceiling in 263-A repaired 3. Paper towel dispenser in 270-B replaced. 4. Wall repaired C1, D1 & 2, 124B, 131A & B, 149-B, 250A, 253B, 257B 5. Closet door in room E2, 261-A repaired. 6. Wall paper peeling F2 repaired 7. In room 251-A bathroom outlet cover changed. 	06/19/2015

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	<p>Housekeeping/Laundry Supervisor, the following was observed:</p> <p>1. Reclaim Unit</p> <p>a. In room 250-A, paint was chipped on the bottom corner of the wall between the bathroom and shelf and also on the bathroom door frame. No resident resided in the room. One resident was residing in the room on 5/26/15 during the initial observation.</p> <p>b. In room 251-A, the bathroom outlet cover above the toilet was cracked. One resident resided in the room.</p> <p>c. In room 253-B, the bottom corner of the wall next to the closet had chipped paint. One resident resided in the room.</p> <p>d. In room 257-B, behind the head of the bed at bed 2 the wall had gouges and the cove base was pulling off. Two residents resided in the room.</p> <p>e. In room 261-A, the closet door had chipped wood. No resident resided in the room. One resident was residing in the room on 5/26/15 during the initial observation.</p> <p>f. In room 262-A, the wall between the bathroom and shelf had chipped paint.</p>		<p>8. In138-A bathroom tile was replaced</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken:</p> <p>1. No residents were adversely affected bythe deficits.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</p> <p>a. Staff re-educated related to completionof work orders for any new area of concerns like thoselisted above.</p> <p>b. Housekeeping staff re-educated on 6/12/15to complete work orders and turn them into theirsupervisor if any deficits are identified while they clean their designatedareas each day.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:i.e., what quality assurance program will be put into place.</p> <p>a. Housekeeping /maintenance staff willaudit the identified rooms two times a week for two weeks,then 10% of the rooms on each nursing unit once a week for two months, then every other weekfor two months and then every three weeks for two months. All audits willtotal six months.(See attachment #11)</p> <p>b. Deficits identified will be submittedto the maintenance supervisor</p>	

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	<p>One resident resided in the room.</p> <p>g. In room 263-A, on the ceiling above the window the plaster was peeling off. One resident resided in the room.</p> <p>h. In room 270-B, the toilet paper dispenser was broken in the bathroom. One resident resided in the room.</p> <p>2. Haven unit</p> <p>a. In room C-1, the wall behind the head of the bed was gouged and marred. Two residents resided in the room.</p> <p>b. In Room D-1&2, the wall behind the head of bed was marred and had chipped paint. The cove base behind the door was peeling away from the wall. Two residents resided in the room.</p> <p>c. In Room E-2, the back of the door was gouged and the window sill was chipped. Two residents resided in the room.</p> <p>d. In Room F-2, the wallpaper along the middle of the wall was peeling, and there was white spackle on the wall by bed 2. Two residents resided in the room.</p> <p>3. Eden Unit</p> <p>a. In room 124-B, the wall behind the bed</p>		<p>for repair when identified.</p> <p>c. Audits will be submitted to the Quality Assurance Committee and continue to be conducted for six months to assure continued compliance.</p>				

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R 0000 Bldg. 00	<p>was gouged. One resident resided in the room.</p> <p>b. In room 131-A&B, the wall beside bed 1 and the wall at the head of the bed for bed 2 was gouged. Two residents resided in the room.</p> <p>c. In room 138-A, the bathroom tile was chipped and cracked, the corner wall next to the sink and the wall behind the TV had white plaster and was in need of painting over. The dresser shelf was chipped in front. Two residents resided in the room.</p> <p>d. In room 149-B, paint was chipped on the walls between the bathroom and closet and also between the bathroom and shelf. Two residents resided in the room.</p> <p>Interview with the Maintenance Manager and the Housekeeping/Laundry Supervisor at the time of the tour indicated all areas are in need of repair or cleaning.</p> <p>3.1-19(f)</p> <p>This visit was for a State Residential</p>	R 0000	R000	

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R 0120 Bldg. 00	<p>Licensure Survey.</p> <p>Residential Census: 45 Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with</p>		<p>This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction doesnot constitute admission or agreement by the provider of the truth of the factsalleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it l required by the revisions of federal and statelaw.</p>	

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	<p>dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure annual medication inservices were completed for 4 of 5 licensed staff members. (LPN#1, LPN #2, LPN #3, and LPN #4)</p> <p>Finding includes:</p> <p>Review of the facility inservice book on 6/3/15 at 9:30 a.m., indicated LPN's #1, #2, #3, and #4, who worked in the facility during the calendar year 2014, did not receive annual medication inservices for the calendar year 2014.</p> <p>Interview with the Director of Nursing on 6/3/15 at 11:29 a.m., indicated the QMA received her six hours of annual medication inservice, however, she was not aware about the licensed staff members and she would check with the Wellness Director. Further interview at 12:00 p.m., indicated the Wellness Director had not completed any medication inservices for licensed staff.</p>	R 0120	<p>R 120 Request Desk Review</p> <p>1. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</p> <p>a. The nursing staff notified of the needfor additional inservice regarding medication annually.</p> <p>2. How otherresidents having the potential to be affected by the same deficient practicewill be identified and whatcorrective action(s) will be taken:</p> <p>a. No residents were adversely affected bythe deficits.</p> <p>3. Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does notrecur.</p> <p>a. Nursing - staff re-educated related tocompletion of medication inservice which will be validatedby certificate of course completion and the need to renew annually.</p> <p>4. How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur: i.e., what qualityassurance program will be put into place.</p> <p>a. Assistant Living</p>	06/19/2015

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R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed for medication administration. (Resident #8)</p> <p>Finding includes:</p> <p>On 6/2/15 at 8:50 a.m., QMA #1 was observed preparing medications for Resident #8. The resident received one inhalation of a Spiriva (a respiratory inhaler) inhaler.</p> <p>The record for Resident #8 was reviewed on 6/2/15 at 9:30 a.m. A Physician's order dated 5/22/15, indicated the resident was to receive Spiriva, inhale two capsules daily.</p>	R 0241	<p>Coordinator will audit completion of all training. (See attachments 1#) b. Reports will be submitted to the Quality Assurance Committee and continue to be conducted for any new staff member hired.</p> <p>R 241 Request Desk Review 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. The physician notified of medication error. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. No residents were adversely affected by the deficits. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. a. Nursing - staff re-educated related to administration of medications. 4. 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.</p>	06/19/2015

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R 0354 Bldg. 00	<p>Interview with QMA #1 on 6/2/15 at 9:40 a.m., indicated that she only had the resident inhale one capsule instead of two.</p> <p>Interview with the Wellness Director on 6/3/15 at 11:15 a.m., indicated the resident should have inhaled two capsules rather than one and the Physician's order wasn't followed as written.</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on record review and interview, the facility failed to ensure a transfer form was completed for 1 of 2 closed</p>	R 0354	<p>a. Assistant Living Coordinator will monitor medication pass for 10% of residents receiving medication twice weekly and record. Audits to include all shifts for a total of six months. (See attachment #2) b. Reports will be submitted to the Quality Assurance Committee and continue to be conducted for any new staff member hired.</p> <p>R354 Request Desk Review 1. What corrective action(s) will be accomplished for those residents found</p>	06/19/2015

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	<p>records reviewed. (Resident #5)</p> <p>Finding includes:</p> <p>The closed record for Resident #5 was reviewed on 6/1/15 at 1:50 p.m. The resident was discharged to a private home on 5/7/15. There was no transfer form nor discharge instructions available for review.</p> <p>Interview with the Wellness Director on 6/3/15 at 11:45 a.m., indicated that he could not locate a transfer form or discharge instructions.</p>		<p>to have been affected by the deficient practice.</p> <p>a. Resident #8 no longer resides in the facility</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Impending discharged residents have the potential to be affected</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Re-educate Assisted living nursing staff proper completion of discharge instructions to promote continuity of care.</p> <p>4. 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.</p> <p>a. Assisting Living Coordinator audit, prior to discharge any resident's record to assure that the discharge instruction sheet is completed and submit copy of the completed discharge sheet to the Administrator for six months. (See Attachment #3)</p> <p>b. Monthly audits which will include copy of the actual discharge instruction sheet sent to the Administrator and discussed at the monthly QA meeting to ensure compliance with this citation for six</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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