

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2015
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NAME OF PROVIDER OR SUPPLIER PARK TERRACE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00180928.</p> <p>Complaint IN00180928-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 9, 10, 14, 15, 16, & 17, 2015</p> <p>Facility number: 000221 Provider number: 155328 AIM number: 100267620</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 16 Medicaid: 45 Other: 3 Total: 64</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	F 0000 Please find the attached planof correction for the recertification and state licensure survey. Performed onSeptember 17th, 2015. This provider respectfully requests that the 2567plan of correction be considered the letter of credible allegation and requestsa desk review, in lieu of a post survey revisit.	
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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 0257 SS=D Bldg. 00	<p>Quality review completed by #02748 on September 22, 2015.</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation, interview, and record review the facility failed to maintain comfortable temperatures for 1 of 6 halls reviewed. (E-Hall)</p> <p>Findings include:</p> <p>On 9/9/15 at 12:06 p.m., the thermostat on the E-Hall was set at 69 degrees Fahrenheit.</p> <p>On 9/10/15 at 10:58 a.m., the thermostat on the E-Hall was set at 69 degrees Fahrenheit.</p> <p>On 9/16/15 at 9:31 a.m., the Maintenance Supervisor was interviewed. The Maintenance Supervisor indicated the temperatures are set between 72 and 74 degrees. When the Maintenance Supervisor was queried regarding the observed 69 degrees the Maintenance Supervisor indicated the staff members</p>	F 0257	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· All thermostats on the walls in the common areas will be changed out for programmable thermostats that have the capability to lock and not be tampered with to ensure thermostats are continually set between 72 and 74 degrees.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· All residents have the potential to be affected; New thermostats will be changed so that they can be locked to ensure the thermostats are continually set between 72 and 74 degrees.</p> <p>What measures will be put into place or what systemic</p>	10/16/2015

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F 0272 SS=D Bldg. 00	<p>sometimes adjust the temperature.</p> <p>On 9/17/15 at 11:14 P.M., RN #1 provided the policy, untitled and undated, regarding the temperatures in the building. The policy included, but was not limited to: We follow the state guidelines to keep temps between the ranges of 71-81 in the common areas.</p> <p>3.1-19(h)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p>		<p>changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Newthermostats that cannot be tampered with will be installed so that only the Facility Maintenance director can change the temperature. Common area temps will be set at 72 degrees. ·All Staff will be in-serviced by CEC/designee regarding thermostats, and comfortable temperatures on 10/6/2015. <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> <ul style="list-style-type: none"> ·To ensure compliance, Maintenance Director/designee is responsible for the monitoring of the facility temperatures daily for 4 weeks, and weekly for 6 months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - <p>What date will the deficient practice be completed?</p> <ul style="list-style-type: none"> ·October 16th, 2015 		

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	<p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review the facility failed to complete an accurate comprehensive assessment for 2 of 34 residents reviewed for pressure ulcers. (Resident #121, Resident # 5)</p> <p>Findings include:</p> <p>1. On 9/10/15 at 11:04 a.m., RN #1 was interviewed. RN #1 indicated Resident #121 had Stage 4 pressure ulcers on his</p>	F 0272	<p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? Both residents #5 and #121 found to have beenaffected have been reassessed and care plans updated to reflect pressure ulcers.</p> <p>How willyou identify other residents having the potential to be affected by the same</p>	10/16/2015
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	<p>right and left ischium.</p> <p>On 9/14/15 at 11:14 a.m., Resident #121's clinical record was reviewed. Resident #121 was admitted with diagnoses including, but not limited to, buttocks wound and paraplegia.</p> <p>The DCR note, dated 7/10/15, indicated Resident #121 had a Stage 4 pressure ulcer on his sacrum.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 7/16/15, indicated Resident #121 had a Stage 3 pressure ulcer.</p> <p>The Care Plans included, but were not limited to: Impaired skin integrity related to pressure ulcer, buttocks, stage 4.</p> <p>On 9/15/15 at 3:00 p.m., the MDS (Minimum Data Set) Assessment Coordinator was queried regarding the MDS indication Resident #121 had a Stage 3 pressure ulcer on admission.</p> <p>On 9/15/15 at 3:09 p.m., the MDS Assessment Coordinator indicated the 7/16/15 either contained a data entry error or somewhere in the resident's chart indicated the resident's pressure ulcer had been a Stage 3.</p>		<p>deficient practice and what corrective action will be taken? All residents with current wound have the potential to be affected. All other current residents with wounds have been reassessed and coded per new policies where all wounds will now be listed as either pressure or non-pressure events By 10/2/2015.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Wound rounds will be conducted weekly by IDT team to ensure all wounds are identified and assessed timely and properly. All new wounds will be identified by the nurse and reassessed by the wound nurse to verify that all are coding is correct by 10/2/15 All license staff will be in serviced by Director of Nursing regarding assessing pressure ulcers on 10/6/2015</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? To ensure compliance, the DNS/Designee is responsible for the completion of the skin/wound management CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results</p>		

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	<p>On 9/15/15 at 3:16 p.m., the MDS (Minimum Data Set) Assessment Coordinator indicated the information used to complete the 7/16/15 MDS Assessment had not contained information regarding the stage of the resident's pressure ulcer.</p> <p>On 9/16/15 at 2:00 p.m., the DON provided the MDS Coordinator Job Description, dated 11/14. The policy included, but was not limited to, performs timely, accurate, and complete resident assessments....</p> <p>2. On 9/14/15 at 10:30 a.m., a record review of the MDS was done. The MDS was coded that Resident #5 had no pressure areas to the skin on the annual assessment dated 5/15/15. The quarterly assessments dated 4/9/15 and 8/7/15 also indicated there were no pressure areas to the skin.</p> <p>On 9/14/15 at 9:13 a.m., Resident #5 record's were reviewed. The Physician's progress notes dated 6/12/15, 8/14/15, and 9/10/15 indicated that the Resident had a Decubitus Ulcer to the right gluteal fold.</p> <p>On 9/15/15 at 11:30 a.m., the Infection Control Nurse brought documentation</p>		<p>of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>What date will the deficient practice be completed? October 16th, 2015</p>	

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	<p>indicating that Resident #5 had a stage 2 pressure ulcer to her right gluteal fold, she also verbally indicated that the resident had a pressure ulcer.</p> <p>On 9/15/15 at 3:04 p.m., an observation of Resident #5 reveled a wound to the right gluteal fold with an intact dressing.</p> <p>On 9/14/15 at 2:29 p.m., the MDS Coordinator indicated she did not know that Resident #5 had a pressure area. She indicated the MDS was coded for no pressure.</p> <p>On 9/16/15 at 4:00 p.m., the Director of Nursing provided a policy titled MDS Coordinator Position Description. The policy indicated that the MDS coordinator performs timely, accurate, and complete resident assessments using the RAI tools (Resident Assessment Instrument).</p> <p>3.1-31(a)</p>			

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide necessary care and services. The facility failed to monitor the dialysis access site daily and following dialysis in 1 of 4 residents reviewed for dialysis. (Resident #4)</p> <p>Findings Include:</p> <p>On 9/14/2015 9:17 a.m. review of Resident #4 clinical record review indicated her diagnosis indicated, but not limited to, arthropathy with neurological disorder, end stage renal disease, diabetes, nonorganic psychosis, polynueropathy, heart attack.</p> <p>A physician's order dated 7/28/15 to daily check fistula site for thrill and bruit - palpate.</p>	F 0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #44 found to be affected has been assessed for any negative outcomes. Resident's access site is assessed daily and following dialysis by a Nurse per physician's orders.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents receiving dialysis have the potential to be affected. All residents currently on dialysis will be audited to ensure care plan and treatment record are followed per physician's orders by 10/2/2015. Nursing staff will be in-serviced on dialysis protocols pre/post return by October</p>	10/16/2015

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	<p>On 9/15/15 at 10 a.m. the August TAR (Treatment Administration Record) indicated for the month of August the thrill and bruit was only checked 2 times on August 7 and August 10, 2015.</p> <p>A Care Plan for hemodialysis plan of care from 4/20/15-9/10/15 indicated: femoral hip access history of multiple failed arterial venous sites Goal: access site will be free of sign and symptoms of infection Interventions: dialysis is on M-W-F check for graft site for bleeding, infection, pain or drainage post procedure complete vital signs on return prior to and return from dialysis document post dialysis weight after each treatment report labs the box for checking the thrill and bruit was not marked in the care plan to be checked.</p> <p>A policy was received by RN #1 titled Dialysis Care, dated 1/2015 which included, but was limited to, the dialysis residents will be assessed the residents access site every shift to include the thrill and bruit, condition of skin at site, drainage, pain warmth, redness and</p>		<p>16th,2015 by Director of Nursing. Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur? Charge nurse/designee will audit charts dailyto ensure physician orders are followed regarding dialysis. Nursing staff will be in-serviced on dialysisprotocols pre/post return by October 16th, 2015 by Director ofNursing. 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? To ensure compliance, the DNS/Designeeis responsible for the completion of the Dialysis CQI tool weekly times 4 weeks, monthly times 6 and thenquarterly until continued compliance is maintained for 2 consecutive quarters.The results of these audits will be reviewed by the CQI committee overseen bythe ED. If threshold of 95% is notachieved an action plan will be developed to ensure compliance. Whatdate will the deficient practice be completed? October 16th, 2015</p>	

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F 0329 SS=D Bldg. 00	<p>recorded on the Medication Administration Record specific to facility policy.</p> <p>3.1-37(a)</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 observation, interview, and</p>	F 0329	Whatcorrective action(s) will be	10/16/2015	

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	<p>record review the facility failed to ensure residents were free from unnecessary medications for 3 of 5 residents reviewed for unnecessary medications. The facility failed to provide adequate indications and gradual dose reductions for an antipsychotic medication. The facility failed to document non-pharmacological interventions for as needed anti-anxiety medications. The facility failed to provide a gradual dose reduction and behavior monitoring for a hypnotic medications. (Resident #126, Resident #4, Resident #65)</p> <p>Findings include:</p> <p>1. On 9/14/15 3:18 p.m., Resident #126's clinical record was reviewed. Resident #126's diagnoses included, but was not limited to, anxiety.</p> <p>Resident #126's admission orders, included, but were not limited to, Diazepam (an anti-anxiety) 2 mg (milligrams) by mouth every 6 hours as needed for anxiety.</p> <p>The interim care plans included, but were not limited to: Resident is at risk for signs and symptoms of anxiety. The interventions included, but were not limited to, encourage activities of interest,</p>		<p>accomplished for those residents found to have been affected by the deficient practice? Residents found to have been affected have been reassessed. Resident #126 has discharged from the facility due to a normally scheduled discharge. Social service director interviewed Resident #65 and assist in identifying non-pharmacological interventions that are effective for reducing insomnia and anxiety. These interventions are care planned. The licensed nurse is documenting non-pharmacological interventions attempted before administering a PRN anti-anxiety medication and the effectiveness of the medication. Resident #4 has been assessed and was given a GDR with ultimate goal of discontinuing med within 14 days. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents receiving psychotropic medications have the potential to be affected. Residents receiving PRN medications will have daily MAR audits for PRN use by 10/2/2015. Those utilizing PRN medications will have chart reviewed to ensure appropriate interventions have been utilized. All residents receiving</p>				

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	<p>encourage to verbalize fears and anxiety, offer validation and reassurance, encourage family to continue to visit, and medications per physicians orders.</p> <p>The nursing notes, dated 9/9/15 at 12:30 a.m., indicated the resident had become anxious when her husband left. The note further indicated the resident had been given Diazepam 2 mg and it had been effective.</p> <p>The September Medication Administration Record was blank regarding the Diazepam.</p> <p>On 9/15/15 at 2:39 p.m., RN #4 was interviewed. RN #4 indicated non-pharmacological interventions should be tried prior to administering an as needed medication. RN #4 further indicated the documentation should be on the back of the Medication Administration Record.</p> <p>2. On 9/14/15 at 4:04 p.m., Resident #65's clinical record was reviewed. Resident #65's diagnoses included, but were not limited to, insomnia and anxiety.</p> <p>The most recent signed physician's recapitulation orders, signed 8/14/15,</p>		<p>psychotropic medications were reviewed by 10/2/2015 to ensure a care plan is in place to provide nonpharmacological interventions prior to dispensing psychotropic medications.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All licensed nursing staff will receive education regarding appropriate interventions prior to administration of psychotropic medication. All licensed nurses will receive education regarding documentation of real time nurses documentation when administering psychotropic medications by Facility Director of Nursing on 10/6/2015. DNS/Designee will review the documentation of administration of PRN psychotropic medications daily to ensure nonpharmacological interventions were attempted prior to medication administration.</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? To ensure compliance, the DNS/Designee is responsible for the completion of the Psychoactive Management CQI tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2</p>		

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	<p>included, but were not limited to: Ambien (a hypnotic medication) 5 mg (milligrams) tablet, give one tablet, orally, daily, at bedtime for insomnia. The start date for the Ambien was 2/11/15. Ativan (an anti-anxiety medication) 0.5 mg tablet, give one tablet, orally, nightly as needed for anxiety.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 6/5/15, indicated resident had a mood score of 0 and had no behaviors. The MDS further indicated resident had received a hypnotic and anti-anxiety medication seven out of seven days during the assessment period.</p> <p>The care plans included, but were not limited to: Resident had episodes of insomnia and anxiety. Interventions included, but were not limited to, encourage resident to participate in facility life and activities to promote night time tiredness and sleep, maintain a calm quiet environment for resident, and encourage resident to participate in counseling visits routinely.</p> <p>The July MAR (Medication Administration Record) indicated the Ativan had been given on July 3, 17, 18, 19, and 20.</p>		<p>consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. What date will the deficient practice be completed? October 16th, 2015</p>	

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	<p>The Nursing Notes and MAR lacked any documented non-pharmacological interventions that had been implemented prior to administering the as needed anti-anxiety medication.</p> <p>On 7/8/15 the Consultation Report from the pharmacist included a recommendation to reduce the Ambien to: Ambien 5 mg every evening as needed, while monitoring for a recurrence of symptoms. The report was declined by the physician without reasoning.</p> <p>The clinical record lacked any documented behaviors related to the Ativan and/or Ambien.</p> <p>On 9/15/15 at 9:46 a.m., the Social Services #1 indicated Resident #65 had no documented behaviors since January of 2015.</p> <p>On 9/17/15 at 11:14 a.m., RN #1 provided the Psychotropic Management Policy, dated 3/15. The policy included, but was not limited to: The facility will initiate a request for a gradual dose reduction at least on the following schedule for each drug...For residents who use a sedative/hypnotic medications a GDR (Gradual Dose</p>			

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	<p>Reduction) must be initiated per the following guidelines....for as long as the resident remain on a sedative hypnotic, the facility should attempt a GDR quarterly unless clinically contraindicated by the physician.</p> <p>All residents who are taking antipsychotic, anxiolytic, sedative/hypnotic, or anticonvulsant medication are required to have a behavior monitoring program in place....</p> <p>2. On 9/14/15 per clinical record review, Resident #4 had diagnoses including but not limited to, end stage renal disease, heart attack, anxiety, neuropathy, adrenal insufficiency, psychosis, chronic obstruction pulmonary disease, chronic pain, and history of chest pain</p> <p>Per Minimum Data Set on 6/26/15 Resident #4 Brief Interviewable Mental Status score is 15/15. It also indicated no behaviors have been exhibited</p> <p>On 11/24/14 an initial order for Risperdal to give 1 tablet, 0.5 mg two times per day for psychosis</p> <p>On 6/10/14 Resident #4 Risperdal was increased to 1 mg two times per day, while being hospitalized, due to visual hallucinations which consisted of feeling</p>			

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	<p>like bugs were crawling on her. She had at the time a urinary tract infection and abnormal labs from her end stage renal disease.</p> <p>On 8/5/14 a Gradual Dose Reduction (GDR) was made to decrease Risperdal to 0.5 mg two times per day On 2/14/14 per GDR Resident #4 was increased to 1 mg two times per day.</p> <p>On 3/16/15 resident #4 was seen by the Licensed Clinical Social Worker (LCSW) for Major depressive affective disorder, who indicated her behavior was within normal limits, often appears depressed and anxious. His treatment objectives included to reduce anxiety and depression.</p> <p>On 5/4/15 resident #4 was seen by LCSW to work on reducing anxiety and depression.</p> <p>Per Clinical record view there were no nursing notes ever indicating the resident was having hallucinations, making false statements or racial slurs.</p> <p>Social service progress notes dated 6/1/15 indicated the clinical behaviors systems review exhibited one episode of being verbally aggressive with staff. Her mood and behavior are stable are within</p>			

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	<p>normal limits at this. Social service notes dated 6/24/15, 7/2/15, 7/8/15, 7/27/15 also indicated no behaviors, and her mood was stable.</p> <p>Per Psychotic Medication review per IDR group on 7/27/15 indicated: Risperdal 1 mg bid (two times a day) for major depressive disorder with psychotic features Last AIMs assessment 7/14/14 Behavior #1 indicated socially inappropriate Behaviors consist of making false statements, racial slurs (resident is black) yells, curses and is demeaning to staff. The Group Behavior Chart for May and June indicated that Resident #4 had only on documented behavior of verbal abuse in May.</p> <p>Care Plan 9/8/15 Resident #4 is at risk for adverse side effects related to psychotropic medication goal - no adverse side effect approach- administer meds as ordered, observe for effectiveness document side effect and notify doctor IDT to review routinely to attempt gradual dose reductions, unless contraindicated by doctor</p>			

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	<p>pharmacist to review med routinely</p> <p>Care Plan for depression has a dx of psychosis with depression approach- allow resident to express feelings and frustration's, emphasize and promote independent encourage activities enc daughters to visits for additional comfort and support medications per order on going counselor to visit</p> <p>On 09/14/2015 4:06 p.m. LPN # 4 was queried about behavior sheets, she indicated Resident #4 for September which had no behaviors noted. LPN #4 indicated she has no problems with resident and believes its all in the way Resident #4 is approached, she has good rapport with resident, but she had heard other CNA and staff talk about her verbal abusiveness. LPN #4 also indicated Resident #4 seems to get most anxious at meal time because she has a hard time feeding herself now because of the arthritis in her hands.</p> <p>On 09/15/2015 9:27:12 a.m. per assistant social worker indicated Resident #4 had no behaviors noted except for one in May for yelling at staff and making false</p>			

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F 0371 SS=E Bldg. 00	<p>statements.</p> <p>On 09/15/2015 10:15 a.m. Unit Manager was queried on why resident was on Risperdal, and he indicated she has been on it since she was admitted and is very anxious, but has not heard of any psychotic behaviors.</p> <p>On 09/16/2015 9:45 a.m. according to the Medication Administration Sheet indicated the Resident #4 was not on any anxiety medication.</p> <p>On 09/16/2015 9:51 a.m. per the Minimum Data Set 6/26/15 indicated behaviors not exhibited. also the resident has psychosis, but no depression or anxiety.</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or</p>				

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	<p>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 store, prepare, distribute, or served food under sanitary conditions for 2 of 2 observations of the kitchen. Food items were observed to be opened and unlabeled, the kitchen floor and dry storage areas had soiled floors, the dry storage area had broken floor tiles, a drawer, under the shelf with the coffee maker on it, had splatters in it, and a package of grapes were open and unlabeled in the walk-in refrigerator. The kitchen staff was observed to handle plates and cups by the edges and rims with their bare hands.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the initial tour of the kitchen on 9/9/15 at 9:22 a.m., an open bag containing 3 hamburger buns was observed with no label or open date on them. The kitchen floor was soiled and the dry storage area floor had broken tile. A drawer, under the shelf containing the coffeemaker, had dried splatters in it. 2. During an observation on 9/14/15 at 10:32 a.m., Dietary Aide #1 was 	F 0371	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All items found will be repaired/cleaned. Several issues identified were corrected when surveyors reported them to facility management. The buns with no open date were discarded. The soiled floor in the kitchen was cleaned, the dry storage area broken tiles have been replaced, the drawer under the coffee maker was cleaned, the eggs were discarded, the grapes with no open date were discarded, by dietary supervisor and Maintenance director. Facility wide in-service will be conducted to educate staff on, cross contamination, proper hand washing techniques, and the handling of clean dishes, and labeling of food in the kitchen.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential of being affected by the deficient practice. Facility wide in-service will be conducted to educate staff on, cross contamination, proper hand washing techniques, and</p>	10/16/2015

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	<p>observed to be pureeing fish for the lunch meal. The recipe required 2 eggs to be added. DA #1 was observed to have 2 eggs in the shell in a small bowl. DA #1 was observed to crack the eggs and place the raw egg into the same bowl that had held the uncracked eggs.</p> <p>3. During an observation of the kitchen on 9/14/15 at 10:45 a.m., a open bag of grapes was observed in the walk-in refrigerator with no date or label on them. The kitchen floor was soiled and the dry storage area floor had broken tiles.</p> <p>4. During an observation of the tray service line on 8/14/15 at 12:05 p.m., Dietary Aide #1 was observed to handle the plate, using her bare hands, by the rim. Dietary Aide #2 was observed to handle the dessert cups by the edges with bare hands. Dietary Aide #2 was observed to use the wall telephone to notify the units of the food carts being ready, reach into the pocket of her uniform and turn off a cell phone, and place her hands on the uniform and apron with no hand hygiene performed. Dietary Aide #3 was observed to handle the salad cups with bare hands by the edges of the cups.</p> <p>During an interview on 9/16/15 at 11:23 a.m., the Dietary Manager indicated the</p>		<p>thehandling of clean dishes, and labeling of food in the kitchen. All food that had been opened was checked toensure an open date label was present. The kitchen area floor was cleaned,tiles were inspected and replaced as needed, drawers were inspected forcleanliness by dietary manager and maintenance director.</p> <p>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur? All staff will be in-serviced to ensure propereducation of facility regulations by 10/6/2015. Dietary manager/designee will inspect all food,kitchen floor, drawers daily to ensure proper storage of food, and propercleanliness of the kitchen. Dietary manager/designee will observe staffhandling tableware/ and hand washing to ensure it is handled properly duringeach meal.</p> <p>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? To ensure compliance, the dietarymanager/designee is responsible for the completion of the dietary sanitation CQItool weekly times 4 weeks, monthly times 6 and then quarterly to encompass allmeals until continued compliance is</p>	

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	<p>kitchen staff had wore gloves on the tray line when serving up food, but the new owners indicated gloves were not to be used. The Dietary Manager indicated she would inservice the staff immediately on how the serve the meals.</p> <p>A policy titled, "Food Storage," dated 2/02 and obtained from the Administrator on 9/17/15 at 11:20 a.m., indicated ready-to-eat food should be marked with the date the container was opened. The policy indicated all refrigerated foods should be covered or wrapped tightly, labeled, and dated.</p> <p>A policy titled, "Handling Clean Equipment and Utensils," original date 2/02, revised 7/15, and obtained from the Adm on 9/17/15 at 11:20 a.m., indicated staff would avoid touching the parts of the equipment and utensils which comes into contact with the food or mouth.</p> <p>A policy titled, "Sanitation of Kitchen," original date 2/02, revised 7/15, and obtained from the Adm on 9/17/15 at 11:20 a.m., indicated the dietary staff will maintain the sanitation of the dietary department through compliance with a written, comprehensive, cleaning schedule.</p> <p>3.1-21(i)(2)</p>		<p>maintained for 2 consecutive quarters. Therresults of these audits will be reviewed by the CQI committee overseen by theED. If threshold of 95% is not achievedan action plan will be developed to ensure compliance.</p> <p>Whatdate will the deficient practice be completed? October 16th, 2015</p>		

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F 0441 SS=E Bldg. 00	<p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <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</p>			
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	<p>for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and sanitary environment to prevent the spread and transmission of infections for 5 of 7 observations of personal care, and 1 of 2 observations of dining. The staff failed to provide hand hygiene during and after performing personal care and delivering food to the residents. (CNA #6, Resident #51, Resident #27, Resident #77, Resident #30, MDS (Minimum Data Set Coordinator), Resident #88)</p> <p>Findings include:</p> <p>1. During an observation on 9/8/15 at 12:08 p.m., CNA #6 was observed to be in the dining room. CNA #6 was observed to wash her hands for 10 seconds. CNA #6 was observed to be administering drinks to the residents. CNA #6 was observed to hug Resident #51 scratch and wipe her face, and put her hands inside of her uniform throughout the administration of drinks. Prior to serving the meal, CNA #6 was</p>	F 0441	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? staff CNA# 6, #1, LPN #3 and RN #3 have been in-services on proper hand washing techniques, and infection control policy to ensure that staff is educated on policy and procedures.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. All staff will be educated and re-trained on policy and procedures regarding hand washing and cross contamination. All staff will be given a post test to ensure compliance.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Facility Clinical education coordinator/designee will monitor staff compliance with facility hand washing policy by</p>	10/16/2015

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	<p>observed to wash her hands for 5 seconds.</p> <p>2. During an observation on 9/15/15 at 10:00 a.m., CNA #1 was observed to be assisting Resident #88 into the bathroom. CNA #1 applied gloves and assisted Resident #88 to stand and pivot onto the commode seat while lowering the resident's slacks and brief. CNA #1 removed Resident #88's brief and placed it in a clear plastic bag, indicating the brief was not wet or soiled. CNA #1 changed her gloves. CNA #1 obtained a clean brief and placed it under her axillary area. CNA #1 obtained 2 (two) clean wet wipes and placed them on the seat of the wheelchair. CNA #1 removed the brief from under her arm and placed it on the resident. CNA #1 assisted Resident #88 to stand and proceeded to use 1 of the wipes to wipe her perianal and rectal area of a brown substance. CNA #1 proceeded to use the soiled wipe to clean the commode seat with the second clean wipe, prior to pulling the resident's brief and slacks up. CNA #1 assisted the resident into her chair and moved the resident to the sink. CNA #1 was observed to turn the water on and assisted with obtaining paper towels for the resident to wash and dry her hands. CNA #1 removed the gloves and pushed the resident into her room.</p>		<p>observing staff daily during resident care and meal service.</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? To ensure compliance, the DNS/Designee is responsible for the completion of the infection control CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>What date will the deficient practice be completed? October 16th, 2015</p>				

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	<p>CNA #1 was observed to remove a candy wrapper and an empty potato chip bag from the resident's overbed table and give Resident #88 the call light before exiting the room. No hand hygiene was performed throughout the procedure. CNA #1 entered the nurse's station and washed her hands for 13 seconds.</p> <p>3. On 9/15/15 at 10:57 a.m., LPN #3 was observed to administer a breathing treatment and a blood sugar check for a Resident #27. LPN #3 sanitized her hands prior to entering the resident's room. LPN #3 used an oxygen saturation machine to check Resident #27's oxygen saturation. LPN #3 applied gloves, used her stethoscope to listen to Resident #27's lungs and placed the stethoscope back around her neck. LPN #3 checked Resident #27's blood sugar and removed the gloves. LPN #3 applied the breathing treatment mask to Resident #27's face and began the breathing treatment. LPN #3 applied new gloves and then removed them. LPN #3 threw away the vial of medication for the breathing treatment. LPN #3 applied a glove to the right hand, used the right hand to place the stethoscope to listen to Resident #27's lungs and placed the ungloved left hand on Resident #27's left arm. LPN #3 removed the oxygen saturation machine from Resident #27's finger and indicated</p>			

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	<p>she would return in 5 minutes. LPN #3 was observed to hold the oxygen saturation machine against her clothing. LPN #3 was observed to remove the single glove from the right hand and performed hand hygiene on her right hand for 5 seconds. LPN #3 returned to the cart and applied a new set of gloves. LPN #3 was observed to cleanse the oxygen saturation machine, the blood sugar machine, and the stethoscope.</p> <p>4. On 9/15/15 at 12:20 p.m., LPN #3 was observed to administer medications via feeding tube to Resident #77. LPN #3 entered room and hand washed for 10 seconds. After LPN #3 administered the medications, LPN #3 completed hand washing for 20 seconds. During the 20 seconds of hand washing, LPN #3's hands were under the running water.</p> <p>5. On 9/16/15 at 7:59 a.m., RN #3 was observed to administer medications to Resident #130. After RN #3 provided Resident #130 medications, RN #3 hand washed for 4 seconds before exiting the resident room to obtain additional medications.</p> <p>6. During an observation on 9/9/15 at</p>			

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	<p>12:12 p.m., the Minimum Data Set Coordinator washed her hands for 7 seconds.</p> <p>A policy was provided by the Infection Control Nurse titled Hand Hygiene that lists the procedure steps for hand washing. Step 6 indicated to use friction for at least 20 seconds prior to delivery food to the residents in the dining room..</p> <p>During an interview on 9/15/15 at 10:26 a.m., CNA #1 indicated hand hygiene should be performed prior to the beginning of care, when going from a dirty to a clean area, and at the end of care. CNA #1 indicated hands should be washed for 10 seconds.</p> <p>A policy titled, "Hand Washing," on 9/15/15 at 11:20 a.m., original date 2/02, revised on 11/14, and obtained from RN #1 indicated dietary staff would wash hands after engaging in activities that would contaminate hands.</p> <p>3.1-18(b)(1) 3.1-18(l)</p>			

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for 13 of 35 rooms observed. Floors were soiled with dirt and debris and sticky urinals with urine present were observed on overbed tables, walls were marred, and a soiled towel were on the resident's 3 drawer chest, a stick on piece of foam was soiled on the side of a resident's overbed table, a bathroom call light string was not attached to the call light, curtains were not secured on the curtain rods, and a commode seat was loose. (rooms 110, 115, 120, 204, 205, 212, 215, 216, 217, 223, 224, 230, 248, 252.)</p> <p>Findings include:</p> <p>1. During an observation on 9/9/15 at 2:05 p.m., Room 204 was observed to have a gray stain on the bathroom floor in front of the commode and the floor was sticky. A brown substance was observed on the commode seat. Dirt and debris</p>	F 0465	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Several items were corrected as soon as facility was made aware of issues during survey. Additionally, a facility wide audit will be conducted to determine other items not listed that need to be repaired.</p> <p>Room 204 – bathroom floor was cleaned, commode was cleaned, cove base was cleaned Room 212 – floor was cleaned Room 215 – paint peeling area was repainted, curtain is on rod, cove base and floors were cleaned Room 216 – cove based was cleaned, wall was repaired, chest of drawers was cleaned, commode seat was repaired, bathroom was cleaned, bathroom floor was repaired. Room 217 – cove base was cleaned, paint chipped was repaired, curtain was hung properly, pull string in bathroom was replaced, urinal was removed from overbed table, floor was cleaned, bathroom was</p>	10/16/2015
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	<p>was observed along the edges and in the corners of the cove base. The same was observed on 9/16/15 at 11:13 a.m.</p> <p>2. During an observation on 9/10/15 at 9:46 a.m., Room 212 was observed to have brown stains on the floor between the bed and the window. The floors had dirt and debris along the edges and in the corners of the cove base. The same was observed on 9/16/15 at 10:57 a.m.</p> <p>3. During an observation on 9/9/15 at 11:42 a.m., Room 215 was observed to have paint peeling above the bed, the curtain partially off of the curtain rod, dirt and debris along the edges and in the corners of the cove base and the floors were sticky next to the bed. The entry room door had brown stains on it. Stagnant, odorous urine was observed in the commode and a wet washcloth was observed lying on the sink in the bathroom. The same was observed on 9/16/15 at 11:00 a.m., except the floor was not sticky but had a gray stain on them and the wet washcloth was gone. The room is shared by 2 (two) residents.</p> <p>4. During an observation on 9/10/15 at 9:21 a.m., Room 216 was observed to have dirt and debris along the edges and in the corners of the cove base and wax build-up was observed in the bathroom.</p>		<p>cleaned, and over bed table was cleaned Room 205 – trash can was removed from the door Room 248 – urinals were removed from bedside table and thoroughly cleaned, denture cup was replaced Room 115 base of commode was clean Room 120 bedpan was cleaned and covered appropriately Room 252 missing air conditioning unit was replaced and area cleaned, cove base was replaced, and repaired. Room 110 the commode was cleaned Room 223 cove base was cleaned, the bathroom was cleaned Room 224 – cove base was cleaned, floor was cleaned, wall was repainted, Room 230 – floor was cleaned, area around toilet paper holder was cleaned, bathroom was cleaned, the sink drain was repaired How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. Facility wide audit of resident rooms and bathrooms will be conducted by the Executive Director to catch other deficient practices by 10/8/2015. All items identified</p>				

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	<p>The wall next to the closet had gouges in it. A 3 drawer chest had a soiled, stained towel on it. The commode seat was loose on the commode. The same was observed on 9/16/15 at 11:08 a.m., except a pillowcase and washcloth was observed in the bathroom on the sink, a black marred area was observed outside of the bathroom floor, and the commode seat was tight. The room was shared by 2 residents.</p> <p>5. During an observation on 9/9/15 at 11:59 a.m., Room 217 was observed to have dirt and debris along the edges and in the corners of the cove base. Paint was chipped off the entry door and the curtain was partially off of the curtain rod. The call light pull string in the bathroom was missing. The same was observed on 9/16/15 at 11:04 as well as a urinal with urine in it was observed on the overbed table, the floor next to the bed was stained with a gray substance, the commode had stagnant, odorous urine in it, a brown stain and a pink emesis basin was observed under the bathroom sink, and a soiled piece of foam was attached to the overbed table.</p> <p>On 9/10/15 at 3 p.m. during Stage 1 observation of resident rooms the following was observed:</p> <p>6. Room 205 at 2:51 a.m. a trash can was</p>		<p>will be addressed and repaired/remedied What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff in-service will be conducted to educate staff on reporting items to facility maintenance director in order for him to schedule the repairs. In-service for all staff will also occur to ensure that they are educated on sanitary practices relating to infection control and unrials being left at bedside. Housekeeping staff in serviced regarding cleaning rooms, cleaning schedules and procedures by Housekeeping Supervisor on 10/1/2015. Housekeeping supervisor will inspect rooms daily to ensure rooms are clean and in good repair. Customer care representatives will check their assigned rooms daily, weekend manager on weekend to ensure cleanliness and in good repair. Any areas needing attention will be corrected as soon as possible. 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? To ensure compliance, the Housekeeping supervisor is responsible for the completion of the resident carerounds-CQI tool</p>		

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	<p>observed holding open the entry door, when trash can was moved away from door and the door closed. The trash can was observed each day of our survey to be propping the door open.</p> <p>7. Room 248 at 9:17 a.m. a urinal was observed sitting on the beside table half full with urine. Two other used urinals was noted in a box of supplies the resident uses for self catheterizing.</p> <p>On 09/10/2015 9:17 a.m., 3 urinals with urine in them, was observed sitting on bedside table.</p> <p>On 09/14/2015 4:01 p.m., in Room 248, 4 empty urinals were observed, two on beside table with small amounts of urine in handles, and two dirty (old bloody type material) on tops of these urinals. Also observed was a denture cup with dentures in it with yellow cloudy liquid sitting in it, beside a TV.</p> <p>On 09/15/2015 8:43 a.m. the same was observed that morning in room 248</p> <p>On 9/15/15 at 3:30 p.m. an interview with the DON(Director of Nursing) about Room 248 and the urinals which were sitting on the bedstand. She indicated he self catheterized himself and is very independent and they have an agreement</p>		<p>weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>What date will the deficient practice be completed? October 16th, 2015</p>				

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	<p>that he leaves them all there till the end of the shift and the CNA's (Certified Nursing Assistant) measure the urine output. The DON was shown the dirty, old brown (blood) on tops of some of the urinals, urine still in some containers in the handles, she indicated the housekeeping had been in and cleaned his room thoroughly yesterday, since he was going to be gone for several days (due to the death of his mother yesterday) already and she would take care of the dirty urinals immediately. Also brought to the DON's attention the dentures sitting in a container in old yellow water. She indicated she would get them cleaned right away.</p> <p>On 9/17/15 at 11:15 a.m. received from RN #1 indicated nursing staff usually clean items in direct resident care procures and clean equipment thoroughly with disinfectant solution according to manufacturers instructions.</p> <p>8. On 9/9/15 at 4:00 p.m., Room # 115 was observed. The base of the commode was observed to black. On 9/16/15 at 10:49 a.m., the same was observed.</p> <p>9. On 9/9/15 at 3:02 p.m., Room #120 was observed. A bed pan was observed to be sitting on the bathroom floor,</p>			

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	<p>uncovered. On 9/16/15 at 10:52 a.m., the same was observed.</p> <p>10. On 9/10/15 at 9:07 a.m., Room # 252 was observed. The heating/air conditioning unit was missing the top front portion and dirt was visible. The cove base by the closet was missing. The cove base in the bathroom was observed to becoming detached from the wall. On 9/16/15 11:06 a.m., the same was observed.</p> <p>11. On 9/10/15 at 11:35 a.m, Room # 110 was observed. The base of the commode was observed to be black. On 9/16/15 at 10:48 a.m., the same was observed.</p> <p>12. During an observation on 9/10/15 at 9:05 a.m., Room 223 was observed to have dirt/debris along the edges and in the corners of the cove base. In the bathroom there was a brownish substance on the wall tile, and grout. The same was observed on 9/14/15 at 8:58 a.m.</p> <p>13. During an observation on 9/10/15 at 9:20 a.m., Room 224 was observed to have dirt/debris along the edges of the cove base, the floor in front of the foot of the bed was dirty, and the wall behind the head of the bed had peeling paint and drywall. The same was observed on</p>			

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	<p>9/14/15 at 9:04 a.m.</p> <p>14. During an observation on 9/10/15/ at 9:46 a.m., Room 230 was observed to have a brown substance on the floor by the recliner chair. The tile and grout under the toilet paper holder had a brown substance on them. The bathroom had a strong urine odor, and the sink was slow draining. The same was observed on 9/14/15 at 9:20 a.m.</p> <p>During an interview on 9/16/15 at 11:30 a.m., the Maintenance Supervision indicated a work repair form was filled out by the staff is work is needed in the building. He indicated every room is checked several times a day for cleanliness. He further indicated when a room is deep-cleaned, the maintenance department will repaint the room if it is needed.</p> <p>During an interview with on 9/16/15 at 2:05 p.m., the Housekeeping Supervisor provided a copy of the daily cleaning schedule and when rooms were scheduled to be deep-cleaned. The Housekeeping Supervisor further indicated the rooms are cleaned daily and deep-cleaned monthly.</p> <p>A policy titled, "Housekeeping," reviewed 5/12 and obtained from the</p>			

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F 9999 Bldg. 00	<p>Administrator on 9/17/15 at 11:20 a.m., indicated the Housekeeping department should maintain a clean, orderly, and sanitary environment within the facility.</p> <p>3.1-19(f)</p>	F 9999	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All new and current employees will be screened for reference checks before hire. All employees hired since July 1st, 2015 have had references checks before hire.</p> <p>How will you identify other residents having the potential</p>	10/16/2015
	<p>3.1-14 PERSONNEL</p> <p>(a) Each facility shall have specific guidelines written and implemented for the screening of prospective employee. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-18-31-3.</p>			

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	<p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 2 of 5 employees, in a total of 10 employees reviewed, had personal references prior to or upon beginning employment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The employee records were reviewed on 9/16/15 at 2:40 p.m. Housekeeper #1 had a hire date of 6/16/15. The employee record lacked any personal references. The employee records were reviewed on 9/16/15 at 2:45 p.m. for the CEC (Clinical Education Coordinator). The CEC had a hire date of 5/4/15. The employee record lacked any personal references. <p>During an interview on 9/16/15 at 4:20 p.m., the Adm (Administrator) indicated the facility was unable to obtain any personal references on employees who had been hired prior to 7/1/15. The Adm further indicated the CEC had not received the TB skin test when she was hired. The Adm indicated the CEC received the TB skin tests after the facility had discovered it.</p>		<p>to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. All new hires will have reference checks completed before hire HR/Payroll Coordinator.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Facility H.R coordinator will verify that all new hires will have had references checked before scheduling employee for orientation. Facility E.D will sign off on all new hires prior to orientation showing that they have completed references checks on their file. HR staff will be in serviced by ED to cover obtaining reference checks by 10/2/2015</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? Facility E.D will verify that all new hires will have personal references checked and will track on a form kept in a binder in his office. Audits will take place Daily x 2 weeks then weekly x 6 weeks. If 95 % compliance is not achieved an action plan will be developed.</p> <p>What date will the deficient practice be completed?</p>		

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	<p>A procedure titled, "Facility Instructions for Conducting a Reference Check," obtained from the Adm on 9/17/15 at 1:25 p.m., indicated the facility would want to make every effort to obtain a complete reference from a previous employer for any of the applicants.</p> <p>A policy titled, "Employee Screening - Tuberculosis (TB)," reviewed on 12/2011 and obtained from the Adm on 9/17/15 at 1:45 p.m., indicated all employees would be screened for TB in accordance with state and federal regulations.</p>		October 16th, 2015		