

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: February 21, 22, 23, 24 and 27, 2012</p> <p>Facility number: 000562 Provider number: 155718 AIM number: 100267150</p> <p>Survey team: Tammy Alley RN TC Toni Maley BSW Donna M. Smith RN Linn Mackey RN Shelly Reed RN DeAnn Mankell RN</p> <p>Census bed type: SNF: 3 SNF/NF: 59 Residential: 22 Total: 84</p> <p>Census payor type: Medicare: 13 Medicaid: 32 Other: 39 Total: 84</p> <p>Stage 2 Sample: 39 Residential Sample: 7</p>	F0000	<p>Submission of the plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Community Northview Care Center. Community Northview Care Center also does not constitute admission that the allegations contained in the survey report are a true and accurate portrayal of the</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>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/02/12 by Suzanne Williams, RN</p>		<p>provision of nursing care and services at this health facility. Community Northview Care Center as a licensed and certified provider recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. The following will serve as the plan of correction and allegation of compliance for the cited deficiencies. If you have any</p>		

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			additional questions please feel free to contact me.	
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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician regarding withheld medications and weight changes for 1 of 16 residents reviewed for physician</p>	F0157	RESIDENT # 8Resident # 8's physician was notified of the instances of the holding of insulin and the resident's weight gain on 3/12/12.All resident's on the Humalog Weight Based/Blood	03/28/2012

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	<p>notification in a stage 2 sample of 39. (Resident # 8)</p> <p>Findings include:</p> <p>Resident #8's record was reviewed on 2/23/12 at 3:05 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus Type II. The physician's rewrite orders, signed 2/8/12, indicated to follow the weight based insulin coverage for the glucometer checks 4 times a day. The physician's order, dated 2/3/12, was a daily weight before breakfast and notify physician if weight more than 2 lbs (pounds) in 1 day or 5 lb over weight.</p> <p>The progress notes indicated the following: On 1/4/12 Called (physician's name) with orders received with no specific order received concerning the insulin withheld and blood sugars.</p> <p>On 1/5/12 at 12:47 p.m., the resident had vomited a large amount of liquid from breakfast earlier; insulin with held with no acute distress noted.</p> <p>On 1/9/12 due to poor appetite insulin withheld at this time with blood sugar of 121.</p>		<p>Glucose Control Flow Scale and all residents on the Heart Failure Zone Protocol have the potential to be affected by this alleged deficient practice. The policies for Humalog Weight Based/Blood Glucose Control and Heart Failure Zone Protocol were reviewed and revisions were made at the time of the review. The Director of Nursing (DON)/Designee will review 5 random residents 5 times a week through March, then 3 times a week for 3 months to ensure their insulin was administered correctly according to the Humalog Weight Based Blood Glucose Scale. Any occurrences of insulin omission will be addressed immediately with the nurse involved and verification of physician notification. The results of the monitoring will be discussed at the next 2 QAA meetings, and provided the insulin is administered as ordered and physician notification is occurring as indicated the monitoring may be discontinued. The Director of Nursing/Designee will review the "Heart Failure Zone Protocol Assessment Forms" for all residents on that protocol to determine that the physician was notified of the resident's weight gain as indicated per the protocol. This monitoring will be completed 5 x /week through March 2012, then will be completed 3 times a week for 3 months. The results of the</p>				

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	<p>On 1/10/12, resident had a poor appetite eating less than 25% so insulin withheld today; no acute distress noted.</p> <p>On 1/13/12 at 1:02 p.m., ate 25% of breakfast and lunch and insulin withheld due to poor oral intake. No distress was noted.</p> <p>On 1/14/12 at 8:00 a.m., the resident was indicated to have no signs or symptoms of hypo/hyperglycemia and was only eating 25% of meals on day shift, so insulin was withheld. No information indicated the physician was notified.</p> <p>On 2/7/12 the physician was scheduled to visit; patient is eating better and blood sugar is better with insulin not being held as often.</p> <p>No further information was indicated concerning the physician notification of the withheld insulin.</p> <p>The "HUMALOG WEIGHT BASED/BLOOD GLUCOSE CONTROL FLOW SHEET" scale indicated, but was not limited to, the following:</p> <p>Weight of 90-109 kg (kilogram): Blood glucose (BS): 100-124 =</p>		<p>monitoring will be discussed at the next 2 QAA meetings, and provided the physician is being notified as indicated per the protocol the monitoring may be discontinued. Licensed Nursing Staff were in-serviced on 3/15/12 to re-educate them on the policies and importance of physician notification. POC Date 3/28/12</p>		

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	<p>coverage of 1 unit (u); 125-149 = 2 u; 150 - 174 = 3 u; 175 - 199 = 4 u; 200 - 224 = 6 u; 225 - 249 = 7 u; 250 - 274 = 9 u; 275 - 299 = 10 u</p> <p>Weight of 110-129 kg (kilogram): Blood glucose (BS): 100-124 = coverage of 2 unit (u); 125-149 = 3 u; 150 - 174 = 4 u; 175 - 199 = 6 u; 200 - 224 = 8 u; 225 - 249 = 9 u; 250 - 274 = 11 u; 275 - 299 = 12 u.</p> <p>On 2/23/12 at 4:10 p.m. during an interview, LPN #4 indicated she would follow, for example, with the 1/27/12 weight of 239.2 lb/108.7 kg (kilograms), the 90 to 109 kg "HUMALOG WEIGHT BASED/BLOOD GLUCOSE CONTROL FLOW SHEET" scale would be followed for the insulin coverage.</p> <p>The following was indicated for 1/1 to 1/27/12 insulin based on the weight on 12/30/11 of 256.0/116.4:</p> <p>The 7 a.m. BS's with insulin coverage's held were as follows: 1/9 BS was 121; 1/10 BS - 113; 1/11 BS -115; 1/13 BS 161; 1/15 BS - 145; 1/16 BS - 131;</p> <p>The 11 a.m. BS's with insulin coverage held were as follows:</p>			

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	<p>1/4 and 1/5 both BS's - 195 no coverage; 1/9 BS - 172, 1/10 BS - 198; 1/11 BS - 199, 1/13 BS - 138; 1/14 - BS - 151; 1/12 BS -187 and 1/16 BS - 177 all with no coverage.</p> <p>On "Comments/Nurse's Notes" of the medication record the following information was indicated related to the insulin withheld: On 1/4 and 1/5, due to vomiting and not eating; On 1/9, nauseated and not eating; On 1/11, 14, 15, 16, and 28 - not eating , n/v on 1/4 and 1/5 and 1/9; On 1/13 - ate only 25%.</p> <p>The resident was in the hospital from 1/19 to 1/27/12.</p> <p>The following was indicated for 1/2012 to 2/3/12 insulin based on the weight on 1/27/12 of 239.2/108.7;</p> <p>The 7 a.m. BS's and insulin coverage held were as follows: On 1/28 - BS - 118; 2/1 - BS - 117; 2/2 - BS 126 all with no coverage; The 11 a.m. BS's: On 2/3 - BS - 114 with no coverage given. The 8 p.m. BS's and insulin coverage were as follows: On 2/2 - BS - 120 with no coverage.</p>			

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	<p>The following was indicated for 2/4/12 to 2/22/12 insulin based on the daily weights:</p> <p>The 7 a.m. BS's and insulin coverage were as follows: On 2/7 - a daily weight of 239.6 lb/108.9 kg; no coverage for the 11 a.m. BS of 201.</p> <p>The "Heart Failure Zone Protocol Assessment Form" indicated the following information: Resident #8's weight gain with no physician notification were as follows: Between 2/6 and 2/7 was a 3 lb weight gain; Between 2/8 and 2/9 was a 2.7 lb weight gain; Between 2/10 and 2/11 was a 2.20 lb weight gain; Between 2/18 and 2/19 was a 4.2 lb weight gain.</p> <p>No further information was indicated related to physician notification.</p> <p>On 2/24/12 at 8:00 a.m. during an interview, LPN #7 indicated Resident #8 was on daily weights. She indicated she would use the resident's daily weights to determine her insulin coverage following the weight based insulin coverage. She also indicated she would wait to see what she eats.</p>			

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	<p>She also indicated if she didn't eat after a meal, she would call the physician and report she did not eat and the insulin was held.</p> <p>On 2/24/12 at 2:00 p.m., LPN #7 indicated the physician notification was placed in the nurse's notes.</p> <p>3.1-5(a)</p>				

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F0164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure privacy during direct care for 2 of 5 residents observed receiving care (Residents # 55 and # 99).</p> <p>Findings include:</p> <p>1. Resident #99 was observed on</p>	F0164	It is the policy of Community Northview Care Center to ensure privacy during care. Resident # 's 99 and 55 had no ill effects from their lack of privacy during care. This alleged deficient practice has the potential to affect all residents. LPN # 5 was counseled by the Director of Nuring (DON) on 3/12/12 regarding his failure to provide	03/28/2012			

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	<p>2/27/12 at 8:39 AM in her room. The door to the room was open and the resident could be seen from the hallway as the LPN # 5 was observed putting a 4 x 4 on her bare left buttock.</p> <p>During an interview with the LPN #5 on 2/27/12 at 10:34 AM, he indicated Resident #99's door should have been shut when he was placing the dressing.</p> <p>2. On 2/24/12 at 8:09 a.m., Resident #55 was observed sitting in his wheelchair next to his bed in his room eating lunch. LPN #7 was observed to pull up Resident #55's shirt as she administered his insulin subcutaneous medication in his right upper abdomen. During this observation the resident's door remained opened with the privacy curtain partially pulled shut between his roommate, who presently was lying in bed.</p>		<p>privacy during resident # 99's care.LPN # 7 was counseled by the Director of Nuring (DON) on 3/12/12 regarding her failure to provide privacy during resident # 55's care.A privacy rounds check sheet was developed.The Administrator/Director of Nursing /Manager on Duty/Designee will complete privacy rounds a minimum of 5 times a week through March , then 3 times a week through June 30, 2012 to ensure staff is ensuring privacy during care. The results of the monitoring will be discussed at the next 2 QAA meetings and provided the staff is ensuring privacy during care the QAA team may determine the monitoring can be discontinued.All staff were in-serviced on either on 3/14/12 or 3/15/12 regarding privacy during care.POC Date: 3/28/12</p>		

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F0223 SS=D	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from rough treatment during care for 1 of 5 residents reviewed for abuse allegations who met the criteria for abuse in a sample of 5. (Resident # 73)</p> <p>Findings include:</p> <p>During an interview on 2/22/12 at 8:45 a.m., Resident #73 indicated that she had been treated roughly by the staff during care.</p> <p>During an interview on 2/23/12 at 12:00 p.m., the Administrator indicated he did remembered the incident and it had been investigated.</p> <p>Record review on 2/23/12 at 12:30 p.m., indicated the resident had reported the incident on 8/23/11 to a nurse. A customer service report was done at that time.</p>	F0223	Resident # 73 was interveiwed by the Administrator on 3/11/12 at 8:01 PM and the resident currently has no concerns related to "rough care" All residents have the potential to be affected by this alleged deficient practice. It is the policy of Community Northview Care Center to ensure resident's are free from abuse. In the future any abuse allegations will be investigated per facility policy and reported to ISDH in a timely manner. The facility abuse policy and procedure was reviewed and minor revisions were made at the time of the review. The facility currently utilizes an Administrative Alert document. The staff were re in-serviced that any staff member with concerns regarding abuse or rough treatment will immediately inform the charge nurse. The charge nurses were re-in-serviced in the event of any resident or staff concerns with any abuse or rough treatment to initiate an administrative alert document and immediately inform the Administator so an investigation	03/28/2012			

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	<p>An investigation report completed and signed by the DON (director of nursing) on 8/23/11, indicated, "This nurse spoke to the (name of CNA # 8) about a complaint regarding the care of (Resident # 73). Resident felt that (the name of CNA #8) and not taken time to talk to her to explain what she was doing, and was not careful r/t (related to) resident's care; causing her pain /discomfort with hygiene care. (Name of CNA #8) was reminded to slow down when caring for her residents; to talk with her residents to allow them to be prepared; and to use caution during care when physically touching all residents to prevent recurrence of this type of situation. (Name of CNA #8) verbalized understanding and stated she would be more careful in the future. (Name of CNA #8) was informed that further complaints regarding care concerns could result in termination."</p> <p>An investigation report competed and signed by the DON on 8/26/2011, indicated, "This nurse did follow up interview with resident (Resident # 73) regarding her complaint about (name of CNA #8) . This nurse asked resident if things were better with (name of CNA #8) since we had</p>		<p>can be initiated. The Administrator/ Social Servies Director or Designee will interview a minimum of 5 interviewable residents weekly for 4 months to ensure their care needs are being met without any concerns of abuse. During the resident council meetings for the next 4 months the meeting coordinator will ask residents if they have any concerns regarding abuse. If any concerns of abuse are identified during any interviews the interviewer will immediately inform the administrator. The results of these interviews will be reviewed at the next 2 QAA meetings and provided the residents have no concerns related to abuse the interviews may be discontinued. All staff were in-serviced on either 3/14/12 or 3/15/12 regarding facility abuse policies and procedures. POC Date: 3/28/12 Addendum to POC 3-23-2012-F223 The facilities abuse policy/Procedure was updated to include immediate notification of the administrator. All employees have been inserviced on the immediate notification of the administrator and staff will be spot cheked and documentation provided to ensure they are aware of who to notify in case of abuse, neglect or misappropriation of residents property. The Administrators phone number is posted at both nurses stations and all staff are</p>	

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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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	<p>spoken last. Resident stated 'I don't really know, she came into my room with another CNA, then stood and watched the other girl provide my care'. I asked resident if (name of CNA #8) talked with her regarding her care. Resident stated 'she did not speak to me or touch me, she just stood there.' This information was relayed to the Administrator."</p> <p>There was no record of the incident being reported to ISDH or that the CNA # 8 was suspended when the event was reported and during the investigation.</p> <p>A payroll update information form dated 8/26/12, indicated CNA #8 was terminated for organizational policies. There was no record that indicated CNA #8 was suspended during this process.</p> <p>Review of a current policy received from the Social Service Director 2/27/12 at 10:10 a.m., titled : Community Northview Care Center Abuse Prevention Policy. indicates ...It shall be the policy of Community Northview ...to assure all residents of this facility are free from verbal...abuse...when any incident of abuse is suspected or determined,all allegations must be reported to the</p>		<p>aware of how to find that number for reporting purposes.</p>	

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	<p>charge nurse and reported to the administrator immediately. The administrator will immediately report to ISDH (Indiana State Department of Health) with a follow up to ISDH with in 5 working days... During the investigation process ... will take steps to prevent further potential abuse...restriction of alleged staff or other agencies from servicing the resident...suspension without pay of any facility staff involved in the alleged violation...."</p> <p>3.1-27(b)</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure</p>	F0225	Resident # 73 was interveiwed by the Administrator on 3/11/12 at 8:01 PM and the resident	03/28/2012			

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	<p>an allegation of abuse was reported to ISDH and the involved CNA was immediately suspended during the investigation to prevent further potential abuse, for 1 of 5 residents reviewed for abuse allegations who met the criteria for abuse in a sample of 5. (Resident # 73)</p> <p>Findings include:</p> <p>During an interview on 2/22/12 at 8:45 a.m., Resident #73 indicated that she had been treated roughly by the staff during care.</p> <p>During an interview on 2/23/12 at 12:00 p.m., the Administrator indicated he did remembered the incident and it had been investigated.</p> <p>Record review on 2/23/12 at 12:30 p.m., indicated the resident had reported the incident on 8/23/11 to a nurse. A customer service report was done at that time.</p> <p>An investigation report completed and signed by the DON (director of nursing) on 8/23/11, indicated, "This nurse spoke to the (name of CNA # 8) about a complaint regarding the care of (Resident # 73). Resident felt that (the name of CNA #8) and not taken time to talk to her to explain what she</p>		<p>currently has no concerns related to "rough care" All residents have the potential to be affected by this alleged deficient practice. It is the policy of Community Northview Care Center to ensure resident's are free from abuse. In the future any abuse allegations will be investigated per facility policy and reported to ISDH in a timely manner. The facility abuse policy and procedure was reviewed and minor revisions were made at the time of the review. The facility currently utilizes an Administrative Alert document. The staff were re in-serviced that any staff member with concerns regarding abuse or rough treatment will immediately inform the charge nurse. The charge nurses were re-in-serviced in the event of any resident or staff concerns with any abuse or rough treatment to initiate an administrative alert document and immediately inform the Administrator so an investigation can be initiated. The Administrator/ Social Servies Director or Designee will interview a minimum of 5 interviewable residents weekly for 4 months to ensure their care needs are being met without any concerns of abuse. During the resident council meetings for the next 4 months the meeting coordinator will ask residents if they have any concerns regarding abuse. If any concerns of abuse are identified during any of the interviews</p>	

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	<p>was doing, and was not careful r/t (related to) resident's care; causing her pain /discomfort with hygiene care. (Name of CNA #8) was reminded to slow down when caring for her residents; to talk with her residents to allow them to be prepared; and to use caution during care when physically touching all residents to prevent recurrence of this type of situation. (Name of CNA #8) verbalized understanding and stated she would be more careful in the future. (Name of CNA #8) was informed that further complaints regarding care concerns could result in termination."</p> <p>An investigation report competed and signed by the DON on 8/26/2011, indicated, "This nurse did follow up interview with resident (Resident # 73) regarding her complaint about (name of CNA #8) . This nurse asked resident if things were better with (name of CNA #8) since we had spoken last. Resident stated 'I don't really know, she came into my room with another CNA, then stood and watched the other girl provide my care'. I asked resident if (name of CNA #8) talked with her regarding her care. Resident stated 'she did not speak to me or touch me, she just stood there.' This information was</p>		<p>the interviewer will immediately inform the administrator. The results of these interviews will be reviewed at the next 2 QAA meetings and provided the residents have no concerns related to abuse the interviews may be discontinued. All staff were in-serviced on either 3/14/12 or 3/15/12 regarding facility abuse policies and procedures.POC Date: 3/28/12Addendum To POC 3-23-2012The facilities policy/procedure was updated to include immediat notification of the administrator. All employees have been inserviced on the immediate notification of the administrator and staff will be spot checked and documentation provided to ensure they are aware of who to notify in case of abuse, neglect or misappropriation of residents property. The administrators phone number is posted at both nurses stations and all staff are aware of how to contact for reporting purposes.</p>				

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	<p>related to the Administrator."</p> <p>There was no record of the incident being reported to ISDH or that the CNA # 8 was suspended when the event was reported and during the investigation.</p> <p>A payroll update information form dated 8/26/12, indicated CNA #8 was terminated for organizational policies. There was no record that indicated CNA #8 was suspended during this process.</p> <p>Review of a current policy received from the Social Service Director 2/27/12 at 10:10 a.m., titled : Community Northview Care Center Abuse Prevention Policy. indicates ...It shall be the policy of Community Northview ...to assure all residents of this facility are free from verbal...abuse...when any incident of abuse is suspected or determined,all allegations must be reported to the charge nurse and reported to the administrator immediately. The administrator will immediately report to ISDH (Indiana State Department of Health) with a follow up to ISDH with in 5 working days... During the investigation process ... will take steps to prevent further potential abuse...restriction of alleged staff or</p>			

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	<p>other agencies from servicing the resident...suspension without pay of any facility staff involved in the alleged violation...."</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure its abuse prevention policy and procedure was implemented, related to the failure to ensure an allegation of abuse was reported to ISDH and failure to immediately suspend the involved CNA during the investigation to prevent further potential abuse, for 1 of 5 residents reviewed for abuse allegations who met the criteria for abuse in a sample of 5. (Resident # 73)</p> <p>Findings include:</p> <p>During an interview on 2/22/12 at 8:45 a.m., Resident #73 indicated that she had been treated roughly by the staff during care.</p> <p>During an interview on 2/23/12 at 12:00 p.m., the Administrator indicated he did remembered the incident and it had been investigated.</p> <p>Record review on 2/23/12 at 12:30 p.m., indicated the resident had</p>	F0226	Resident # 73 was interveiwed by the Administrator on 3/11/12 at 8:01 PM and the resident currently has no concerns related to "rough care" All residents have the potential to be affected by this alleged deficient practice. It is the policy of Community Northview Care Center to ensure resident's are free from abuse. In the future any abuse allegations will be investigated per facility policy including suspension of alleged employee and reporting to ISDH in a timely manner. The facility abuse policy and procedure was reviewed and minor revisions were made at the time of the review. The facility currently utilizes an Administrative Alert document. The staff were re in-serviced that any staff member with concerns regarding abuse or rough treatment will immediately inform the charge nurse. The charge nurses were re-in-serviced in the event of any resident or staff concerns with any abuse or rough treatment to initiate an administrative alert document and immediately inform the Administator so an investigation can be initiated. The	03/28/2012			

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	<p>reported the incident on 8/23/11 to a nurse. A customer service report was done at that time.</p> <p>An investigation report completed and signed by the DON (director of nursing) on 8/23/11, indicated, "This nurse spoke to the (name of CNA # 8) about a complaint regarding the care of (Resident # 73). Resident felt that (the name of CNA #8) and not taken time to talk to her to explain what she was doing, and was not careful r/t (related to) resident's care; causing her pain /discomfort with hygiene care. (Name of CNA #8) was reminded to slow down when caring for her residents; to talk with her residents to allow them to be prepared; and to use caution during care when physically touching all residents to prevent recurrence of this type of situation. (Name of CNA #8) verbalized understanding and stated she would be more careful in the future. (Name of CNA #8) was informed that further complaints regarding care concerns could result in termination."</p> <p>An investigation report competed and signed by the DON on 8/26/2011, indicated, "This nurse did follow up interview with resident (Resident # 73) regarding her complaint about</p>		<p>Administrator/ Social Servies Director or Designee will interview a minimum of 5 interviewable residents weekly for 4 months to ensure their care needs are being met without any concerns of abuse. During the resident council meetings for the next 4 months the meeting coordinator will ask residents of they have any concerns regarding abuse. If any concerns of abuse are identified during any of the interviews the interviewer will immediately inform the administrator. The results of these interviews will be reviewed at the next 2 QAA meetings and provided the residents have no concerns related to abuse the interviews may be discontinued. All staff were in-serviced on either 3/14/12 or 3/15/12 regarding facility abuse policies and procedures.POC Date: 3/28/12Addendum to POC 3-23-2012The facilities abuse policy/procedure was updated to include immediate notification of the administrator. Employees have been inserviced on the immediate notification of the adminstrator and staff will be spot checked and documentation provided to ensure they are aware of who to notify in case of abuse, neglect or misappropriation of residents property. The Administrators phone number is posted at both nurses stations and all staff are aware of how to contact for</p>		

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	<p>(name of CNA #8) . This nurse asked resident if things were better with (name of CNA #8) since we had spoken last. Resident stated 'I don't really know, she came into my room with another CNA, then stood and watched the other girl provide my care'. I asked resident if (name of CNA #8) talked with her regarding her care. Resident stated 'she did not speak to me or touch me, she just stood there.' This information was relayed to the Administrator."</p> <p>There was no record of the incident being reported to ISDH or that the CNA # 8 was suspended when the event was reported and during the investigation.</p> <p>A payroll update information form dated 8/26/12, indicated CNA #8 was terminated for organizational policies. There was no record that indicated CNA #8 was suspended during this process.</p> <p>Review of a current policy received from the Social Service Director 2/27/12 at 10:10 a.m., titled : Community Northview Care Center Abuse Prevention Policy. indicates ...It shall be the policy of Community Northview ...to assure all residents of this facility are free from</p>		reporting purposes.				

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	<p>verbal...abuse...when any incident of abuse is suspected or determined,all allegations must be reported to the charge nurse and reported to the administrator immediately. The administrator will immediately report to ISDH (Indiana State Department of Health) with a follow up to ISDH with in 5 working days... During the investigation process ... will take steps to prevent further potential abuse...restriction of alleged staff or other agencies from servicing the resident...suspension without pay of any facility staff involved in the alleged violation...."</p> <p>3.1-28(a)</p>			

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F0244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on record review and interview, the facility failed to resolve grievances regarding food palatability for 3 of 12 months for resident council concerns reviewed (January 2012, February 2012, December 2011) for 15 of 29 residents interviewed during stage 1 sample. (Resident # 124, 82, 125, 42, 98, 21, 30, 96, 27, 110, 54, 61, 55, 59, 111)</p> <p>Findings Include:</p> <p>Review of February 2012, January 2012 and December 2011 Resident Council Minutes indicated Residents had expressed repeated concerns regarding food satisfaction as follows:</p> <p>a.) 2/3/12-Resident Council Minutes: Food is cold and does not taste good. The food doesn't always taste good. Rice and beans and "weines" are not hot when served. Egg salad sandwich with vegetable beef soup is menued two or more times per week, especially in the evenings. The</p>	F0244	<p>It is the practice of Community Northview Care Center to resolve grievances in a timely manner. The facility has started to utilize a cart with various condiments, coffee, and hot tea on the cart on each of the units that is taken to the unit just prior to the meal cart being delivered. Included on the cart is a microwave, and the assigned staff that pass the hall trays were in serviced to warm the resident's food prior to service and then additionally ask the resident, before the staff leaves the room, if their food is hot enough. The staff also has hot coffee and hot water for tea available on the cart in the event the resident requests these drinks. Facility Dietary Manager and/or Administrator/Designee will attend (by invitation) resident council meetings every month to inquire about food issues. Facility will continue to utilize form for facility response and corrective action following any concerns voiced in resident council. The administrator/designee and the appropriate department head will discuss any resident concerns</p>	03/28/2012	

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	<p>facility is serving fish squares instead of cat fish. Residents have requested cat fish previously. The fish patties are dry and residents couldn't cut it. Tater tots are on the menu again (no indication if it's good or bad).</p> <p>Facility Response and Corrective action 2/15/12: To correct these problems we need the dates when the meal was served. Facility will review concerns with staff. The Food Services Supervisor will go over new menus and remove rice and beans & "weines". Cat fish is not on menu, but will see what they (Resident council) want to replace these [disliked meals] meals with [catfish].</p> <p>b.) 1/4/12-Resident Council Minutes Residents want onions and potatoes(fried). Potatoes are served cold & hard Tater tots are back [no indication if positive or negative]. Residents want salt and pepper on tables again. Food at lunch and supper are terrible-no taste.</p> <p>Facility Response and Corrective Action -1/19/12 The facility has been going by the</p>		<p>and initiate an action plan to address this concern. The results of this action plan will be reported to the resident council president and the resident with the concern no later than 10 days after the meeting and also follow-up at the next month's council meeting. A test tray will be sampled 5 times a week through March on alternating days and meals by various department heads for temperature and palatability. A test tray will be sampled 3 times a week through June 30 by various department heads for temperature and palatability. The results of these audits will be turned into the administrator and reviewed on a weekly basis by the Administrator and Dietary Manager. The facility has implemented a weekend manager every weekend. This will be a rotation among several department heads. One of these individuals' responsibilities will be to monitor meal service and interview residents regarding the temperature and palatability of their meal. Dietary Manager/Administrator/Designee will interview a minimum of 20 interviewable residents weekly through the end of April 2012, then 10 residents per week through June 30, 2012 regarding food temperature and palatability. All results of resident interviews will be brought to Administrator for review and any needed</p>		

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	<p>recipes. The Food Services Supervisor will discuss with the dietitian the possibility of changing recipes. The facility does check food temperatures. French fries were taken off the menus, not tater tots. Will discuss salt on the table with the Administrator. Food services supervisor asked for examples of food that did not taste good.</p> <p>c.) 12/6/11-Resident Council Minutes Pork chops were tough and awful, some were soggy and didn't seem to be done. Potatoes are never done and they are always cold and have no taste. There was poor service on the weekend. Food that go to the rooms are always cold. Bacon is still being counting will not give more than 2 slices and that is not enough to make a sandwich. Week-ends are poor, food is cold, staff get upset when they are asked to warm stuff up.</p> <p>12/10/11 Facility Response and Corrective Action: The pork chops were a different brand-we will not use them again. The Food Services Supervisor asked when the residents were dissatisfied with taste or temperature. The</p>		<p>actions. Family members will continue to be interviewed utilizing QIS food interview questions every other month during customer calls. Facility Dietary Manager has developed a list of food alternatives that may be requested at all meals. This list has been laminated and placed in all resident rooms. Dietary Manager will inform residents of this list and that they may request any item from this list during their admission interview. Current residents will have list placed in their room by 3/28/12 along with information that they may request any alternative on the list. A form was developed for the dishwasher to document food items that have a high leave amount. The Dietary Manager will review this form weekly to monitor for trends and possible revisions to the menu. A summary of results from resident and staff interviews will be discussed at the next 2 QAA meetings and the team will determine and need/frequency of continued interviews depending on the results of the interviews. POC Date: 3/28/12</p>		

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	<p>residents couldn't say (a date) the facility will keep and eye on this. Test trays show temps are high when they leave kitchen. If you want more bacon you will have to request it. Regarding weekends: Food is sent out hot from kitchen If you would let staff know when this happens we could fix it ASAP. The dietary department will continue to watch and fix if possible.</p> <p>During a 2/23/12, 12:30 p.m., interview, Resident #21, who was the Resident Council President, indicated the Activity Director assisted the Resident Council by completing the concern form and reporting the follow-ups to the council. Resident #21 indicated she did not remember what concerns had been voiced because she allowed the Activity Director to handle that aspect of council.</p> <p>During a 2/23/12, 12:45 p.m., interview the Activity Director indicated when complaints and concerns were expressed in Resident Council she completes a form. The form was routed to the department of the area of concern. The department head must address the concern and respond back. When queried, the</p>			

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	<p>Activity Director indicated the concerns with food dissatisfaction did not appear to be resolved because the concern reappeared for a number of months. She indicated the facility's efforts had not appeared to correct the problem to the resident's satisfaction. She indicated the residents had responded to her in a manner that made her believe the food issues remained unresolved.</p> <p>During individual resident interviews, with residents who were determined to be interviewable during the stage 1 survey process, the following concerns regarding food satisfaction were expressed:</p> <p>a.) During a 2/21/12, 2:27 p.m., interview with Resident #124 when questioned: "Does the food taste good and look appetizing?", Resident #124 responded no. Resident #124 indicated room trays were cold and food items were spilled into each other making the meal unappealing.</p> <p>During a 2/21/12, 2:27 p/m., interview with Resident #124 when questioned: "Is the food served at the proper temperature?", Resident #124 responded no.</p> <p>b.) During a 2/21/12, 2:38 p.m.,</p>						

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	<p>interview with Resident #82 when questioned "Does the food taste good and look appetizing?", Resident #82 responded no. Resident #82 indicated "the food is not seasoned to suit me."</p> <p>When questioned "Is the food served at the proper temperature?", Resident #82 responded no. Resident #82 indicated, "Most of the time it's cold."</p> <p>c.) During a 2/21/12, 3:13 p.m., interview with Resident #125 when questioned, " Is the food served at the proper temperature?" Resident #125 indicated, "Scrambled eggs are barely warm every morning."</p> <p>d.) During a 2/22/12, 8:37 a.m., interview with Resident #42 when questioned "Is the food served at the proper temperature?", Resident #42 responded no. Resident #42 indicated food was not warm at supper time.</p> <p>e.) During a 2/22/12, 9:40 a.m., interview with Resident #98 when question "Does the food taste good and look appetizing?", Resident #98 responded no. When questioned, "Is the food served at the proper temperature?" Resident #98</p>			

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	<p>responded no. Resident #98 indicated "Food is sometimes not at the proper temperature, just warm."</p> <p>f.) During a 2/22/12, 8:22 a.m. interview with Resident #21 when questioned "Is the food served at the proper temperature?" Resident #21 responded no. Resident #21 indicated sometimes food was not hot.</p> <p>g.) During a 2/21/12, 3:21 p.m., interview with Resident #30 when questioned "Is the food served at the proper temperature?" Resident #30 responded no. Resident #30 indicated breakfast was cold.</p> <p>h.) During a 2/21/12, 2:37 p.m., interview with Resident #96 when questioned "Does the food taste good and look appetizing?" Resident #96 responded no. When questioned "Is the food served at the proper temperature?" Resident #96 responded no. Resident #96 indicated food is neither not nor cold. It's in between.</p> <p>i.) During a 2/21/12, 2:28 p.m., interview with Resident #27 when questioned, "Does the food taste good and look appetizing?" Resident #27 responded no. When question</p>			

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	<p>"Is the food served at the proper temperature?", Resident #27 responded no. Resident #27 indicated, the food was usually on chilly side, usually breakfast and lunch.</p> <p>j.) During a 2/22/12, 9:15 a.m., interview, with Resident #110, when questioned "Does the food taste good and look appetizing?", Resident #110 responded no. Resident #110 indicated meat was not done. When questioned "Is the food served at the proper temperature?" Resident #110 responded no.</p> <p>k.) During a 2/21/12, interview with Resident #61 when questioned "Does the food taste good and look appetizing?" Resident #61 responded no. Resident #61 indicated food doesn't always taste good."</p> <p>l.) During a 2/21/12, 2:56 p.m., interview with Resident #54 when questioned "Does the food taste good and look appetizing?" Resident #54 responded no. Resident #54 indicated food was not really appetizing</p> <p>m.) During a 2/21/12, 12:06 p.m., interview with Resident #55 when</p>			

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	<p>questioned " Is the food served at the proper temperature?", Resident #55 responded no. Resident #55 indicated food was cold every day and every meal. Breakfast was always cold.</p> <p>n.) During a 2/22/12, 9:47 a.m., interview with Resident #59 when questioned "Does the food taste good and look appetizing?", Resident #59 responded no. Resident #59 indicated "I do not like any of the food."</p> <p>o.) During a 2/21/12, 2:00 p.m., interview with Resident #111 when questioned "Is the food served at the proper temperature?" Resident #111 responded no. Resident #111 indicated most of the time the food was cold.</p> <p>During a 2/23/12, 12:50 p.m., interview, the Food Services Supervisor indicated:</p> <p>There was not a formal method to look at the foods residents leave uneaten to determine if the uneaten food was a result of disaffection with the food item. She indicated the dietary department "keeps an eye on" leftovers but do not document, interview residents about the leftovers</p>						

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	<p>or modify menus following their observations.</p> <p>She additionally indicated she and the Registered Dietitian had not yet reviewed the menus for variety. She had changed one of the egg salad meals due to frequency.</p> <p>She also indicated she completed a test tray once a week. She indicated she did taste food but didn't document her taste results. She indicated no other employee was assigned to taste testing.</p> <p>She indicated she had not done any quality checks to ensure staff are warming resident food when requested.</p> <p>She indicated all hall test trays are sent with note saying test tray on them. She does no unidentified or surprise trays for testing. She does not complete any action to ensure hall trays are past timely to ensure food temperature is maintain at the proper levels.</p> <p>Review of the complete test tray records for November 2011 through February 2012, which were provided by the Food Services Supervisor on 2/23/12 at 3:30 p.m., indicated the</p>			

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	<p>following:</p> <p>a.) a total of 16 trays were tested during the 4 month period: 9 of 16 test were completed in lunch trays, 4 of 16 were completed for breakfast and 3 of 16 supper.</p> <p>b.) no food tray testing was completed on the weekends.</p> <p>c.) No food tasting was documented.</p> <p>3.1-3(l)</p>				

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F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure a cognitively impaired resident received activities designed to meet the resident's individualized needs for 1 of 6 residents reviewed for activities of 11 who met the criteria for activities for cognitively impaired residents. (Resident # 85)</p> <p>Findings include:</p> <p>The record for Resident # 85 was reviewed on 2/23/12 at 8:40 a.m.</p> <p>Current diagnoses included, but were not limited to, dementia, Alzheimer's disease with depression and agitation.</p> <p>A 2/2/12 cognitive assessment indicated the resident was cognitively impaired.</p> <p>A careplan dated 1/28/12 indicated the resident preferred to attend church and entertainment, watched</p>	F0248	<p>It is the practice of Community Northview Care Center to provide an ongoing program of activities designed to meet each resident's individual needs. Resident # 85 Resident # 85's family member was interviewed on 2/24/12 regarding the resident's interests to meet her individualized</p>	03/28/2012

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	<p>others play games, exercise and coffee club. Approaches included, but were not limited to, do not try to force resident to do anything because she will start fighting you. Staff will offer to assist resident to and from an activity of choice.</p> <p>During an observation on 2/21/12 at 2:59 p.m., Resident # 85 was sitting in her wheelchair in the Dogwood lounge. The television was on in the lounge and a flat electric piano board was sitting on the table in front of the resident. The resident was not attentive to the piano board.</p> <p>During an observation on 2/21/12 at 3:58 p.m., the resident was sitting in the Dogwood lounge at the table. Activity assistant # 9 was leading "just dance" with 3 residents. Just dance was a video exercise program. Resident # 85 was not in front of the television and was not encouraged to participate in the activity. The resident was awake and pulling up her pant legs.</p> <p>During an observation on 2/22/12 at 8:47 a.m., the resident was awake and sitting in her wheelchair in the Dogwood lounge; the television was on but at a very low volume.</p>		<p>needs. Resident # 85 was added to the facility list of 1:1's for 3-5 times a week. The Activity Director in-serviced the activity staff on 3/7/12 regarding encouraging and involving residents in activities in the area they are in even if they are a passive participant. All other cognitive impaired residents have the potential to be affected by this alleged deficient practice. A list of all</p>		

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	<p>During an observation on 2/22/12 at 9:19 a.m., the resident was in her wheelchair in the Dogwood lounge in front of the television. Activity assistant # 9 was leading "just dance" from a chair in a seated position. She was not encouraging Resident # 85 to participate. The resident was sitting in her wheelchair playing with her shirt tail.</p> <p>During a continuous observation on 2/23/12 between 9:41 a.m., and 10:45 a.m., the following was observed:</p> <p>At 9:41 a.m., the resident was in her wheelchair in the Dogwood lounge at the table. At this time, Activity assistant #9 had a group of 5 residents in front of the television leading "just dance". Activity assistant #9 was sitting in a chair. Resident # 85 was not sitting with the group. She was seated behind the group and the activity assistant had her back to the resident. The television sound was at a low level. The resident had her head down and eyes closed. She was not encouraged to participate or spoken to.</p> <p>At 10:06 a.m., the Activity Director came into the lounge and sat on the</p>		<p>residents was reviewed by the activity director and residents who were assessed to need 1:1 activities have been added to 1:1 activities program. The AD will maintain a 1:1 log book with all documentation completed on the 1:1 visits. The AD will review the logs on a weekly basis to ensure the residents are receiving their 1:1 visits. Additionally, the AD will review resident listing on a</p>		

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	<p>couch closest to the television and began talking to several residents. Resident # 85 remained in the same location in the lounge at the table with no activity item in front of her and no one had spoken to her.</p> <p>At 10:11 a.m., Activity assistant #9 came into the lounge and had a conversation with the Activity Director. The Activity Director sat in front of a group of residents in a circle. She began leading the group in exercise. Activity assistant # 9 sat in a chair between two residents. Resident # 85 was still in her wheelchair at the table, behind the group. Neither the Activity Director or the assistant attempted to encourage the resident to participate or spoke to the resident.</p> <p>At 10:18 a.m., Activity assistant #9 gave one resident and the Activity Director a glass of water. Resident # 85 was then taken to the shower room for personal care and returned to the lounge and sat with the group participating in exercise. The Activity Director said hi to the resident and offered her a blanket. She continued to lead the group in exercise, without encouraging Resident # 85 to participate or assist her to participate.</p> <p>At 10:45 a.m., Activity assistant #9</p>		<p>weekly basis to ensure all residents are receiving 1:1 activities as indicated. AD will give reporting at next 2 QAA meetings regarding 1:1 activity program. POC 3/28/12</p>	

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	<p>moved the resident from the group to the sofa area where her husband was sitting for a visit. When Resident # 85 saw her husband she stated "there is my Papa."</p> <p>During a continuous observation on 2/23/12 between 12:43 p.m., and 1:45 p.m., the following was observed:</p> <p>At 12:43 p.m., the resident was brought to the Dogwood lounge and sat in front of the television.</p> <p>Between 1:02 p.m.-1:30 p.m., the resident continued to sit in front of the television. Activity assistant # 9 had 2 residents sitting at the table reading to them. She had her back to Resident # 85 and had not encouraged or brought the resident into the group to listen to the reading.</p> <p>At 1:45 p.m., the resident continued to sit in front of the television, awake and rubbing her hands through her hair and pulling up her pant legs. No staff had spoken to the resident since the beginning of the observation.</p> <p>During observation on 2/24/12 at 9 a.m., Resident # 85 was in her wheelchair in the Dogwood lounge. Activity assistant #9 was assisting</p>				

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	<p>the resident to exercise her arms and the resident participated without resistance.</p> <p>The activity participation attendance sheet was reviewed on 2/23/12 at 2:25 p.m., with the Activity Director. She indicated all the highlighted areas, the resident had participated in. The calendar indicated the resident had attended on 2/2/12, just dance, exercise/coffee club, bible study, and a visitor, On 2/23/12, the calendar indicated the resident attended just dance, exercise/coffee club, storytime and a visitor.</p> <p>During an interview on 2/24/12 at 10:44 a.m., Activity Assistant # 9, indicated Resident # 85 had participated in activities yesterday per the attendance record. When informed the resident was observed not participating, she indicated the resident is "hard to move in her wheelchair." She indicated the resident will move her arms and legs during exercise by herself. She also indicated if attendance activity is highlighted, the resident had participated or has been encouraged to participate.</p> <p>3.1-33(a)</p>			

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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure resident bathrooms and resident rooms were clean, neat and/or in good repair and resident room doors were in good repair and free of marred surfaces for 3 of 3 units observed. (Rosewood Court, Dogwood Court and Robin Court) (Resident rooms 104, 203, 204, 308, 118, 108 and 122) (Resident room doors 203, 204, 202, 201 and the laundry room door). This deficient practice had the potential to impact 62 of 62 residents residing in the facility.</p> <p>Findings Include:</p> <p>During a 2/22/12, 8:28 a.m. observation of Room 104 window side of room, there was an area behind the headboard which had some black streaks about 4 feet in length.</p> <p>During a 2/21/12, 11:36 a.m. observation of room 203, the bathroom floor at baseboards was soiled with gray build up and there was brown build up around toilet</p>	F0253	<p>It is the practice of Community Northview Care Center to ensure maintenance services are provided to maintain a sanitary, orderly and comfortable interior. Room # 104- The wall behind the headboard was repainted on 3/14/12. Room # 203- The waxy build-up in the bathroom around the baseboards and toilet base was cleaned on 3/1/12. The large chip on the door by the handle has been repaired. The</p>	03/28/2012	

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	<p>base. The inner bathroom door had a large 3 foot by 2 inch chip on the door by the handle. The wall by entry to the room had peeled paint approximately a foot in size.</p> <p>During a 2/21/12, 11:35 a.m. observation of room 204, the bathroom floor at the baseboards was soiled with dark residue. There were scuffs on the wall beside toilet 12 inches above the floor and approximately 4 feet wide.</p> <p>During a 2/21/12, 2:13 p.m., observation of room 308, there were 6 small paint chips on the wall by the bed.</p> <p>During a 2/21/12, 11:55 a.m., observation of room 118, the over the toilet style seat riser had a broken right arm. The arm was taped with white tape. The tape did not cover the break.</p> <p>During a 2/23/12 9:30 a.m., environmental tour accompanied by both the Maintenance supervisor and the Administrator the following environmental concerns were noted:</p> <p>a.) The exit door to the laundry room was scuffed and marred.</p>		<p>wall by the entry to the room was painted on 3/15/12. Room # 204- The bathroom floor was cleaned on 3/1/12. The bathroom was repainted on 3/14/12. Room # 308- The wall by the bed was repainted on 3/15/12. Room # 118- The toilet seat riser was replaced on 3/12/12. Exit Door to laundry room- Please note this door is in a vestibule area not generally accessible or visible to residents or family members. The exit door to the laundry room has been repaired. Room 108- The wall in the</p>	

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	<p>b.) Room 108 had multiple black scratches on the wall by the door bed. During an interview at this time the Maintenance Supervisor indicated the marks were from a wheelchair. There was a urinal on the back of the toilet. There was no labeling to identify which resident was using this urinal. During an interview at this time, the Administrator indicated personal items should be marked or labeled to identify which resident is using said items.</p> <p>c.) Room 122 had a gray filmy residue on the bathroom floor rimming the baseboard.</p> <p>d.) Rooms 203, 204, 202, and 201 had marred and scuffed doors. During an Interview at this time, The Maintenance Supervisor indicated door maintenance was a constant ongoing process due to wheelchairs and machinery making contact with the doors.</p> <p>3.1-19(f)</p>		<p>room was painted on 3/14/12. Immediately upon identification on 2/23/12, a new urinal was obtained and labeled for the resident that used the urinal. Room # 122- The bathroom floor was cleaned on 3/1/12. Room #s 201, 202, 203, & 204 were sanded by maintenance staff on 2/23/12 to smooth the surface of the door. Maintenance staff have checked all resident room doors for scarring and marring, and resident rooms for scrapes and marring on the walls. Housekeeping</p>		

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			supervisor has checked all resident bathrooms for build-up on the bathroom floor any additional rooms with noted concerns have been cleaned. All bathroom floors will be replaced with a solid piece of a no wax vinyl. To date approximately 20 bathroom floors have been replaced and this will continue until all floors are completed. Administrator and Maintenance staff will complete monthly facility rounds to evaluate progress of room painting and floor replacement. The	

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			results of these rounds will be discussed at the quarterly QAA meetings. Staff was in-serviced on either 3/14/12 or 3/15/12 regarding the importance of completing a maintenance request if the staff identify any issues with scarring, marring on the resident room walls, doors, or bathrooms, so maintenance staff can address the issues in a timely manner.POC: 3/28/12	

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to initiate a plan of care for activities for 1 of 6 residents reviewed for activities of 11 who met the criteria for activities for cognitively impaired residents. (Resident # 85)</p> <p>Findings include:</p> <p>The record for Resident # 85 was reviewed on 2/23/12 at 8:40 a.m.</p> <p>Current diagnoses included, but were not limited to, dementia, Alzheimer's</p>	F0279	Resident # 85Resident # 85's health care plan (HCP) was reviewed and revised to include the resident needs for encouragement and assistance to participate. Additionally, the HCP was updated to include her individual interests.Resident's who are unable to express their individual activity interests or actively participate in activities will have their HCP's reviewed and updated as indicated to include their need for encouragement, assistance to participate, and their individual interests. The schedule for updating their HCP's will coincide with their next health	03/28/2012	

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	<p>disease with depression and agitation.</p> <p>A 2/2/12 cognitive assessment indicated the resident was cognitively impaired.</p> <p>A careplan dated 1/28/12 indicated the resident preferred to attend church and entertainment, watched others play games, exercise and coffee club. Approaches included, but were not limited to, do not try to force resident to do anything because she will start fighting you. Staff will offer to assist resident to and from an activity of choice.</p> <p>A plan of care dated 8/24/11 indicated the resident had hearing deficits with approaches that included, but were not limited to, conscious of resident position in a groups, activities to promote proper communication with others.</p> <p>The plan of care for activities did not address the residents need for encouragement and passive participation assistance. The plan did not address the resident's individual interests and did not individualize strategies to enhance participation.</p> <p>During an observation on 2/21/12 at</p>		<p>care plan conferecne date. All HCP's will be reviewed by the end of a 3 month period. AD will provide to Adminsitrator an updated weekly list of HCP's that have been updated for 3 months until all HCP's have been updated.The AD will give a report at the next 2 QAA meetings to update the team on the progression of the HCP updates.POC Date: 3/28/12</p>		

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	<p>2:59 p.m., Resident # 85 was sitting in her wheelchair in the Dogwood lounge. The television was on in the lounge and a flat electric piano board was sitting on the table in front of the resident. The resident was not attentive to the piano board.</p> <p>During an observation on 2/21/12 at 3:58 p.m., the resident was sitting in the Dogwood lounge at the table. Activity assistant # 9 was leading "just dance" with 3 residents. Just dance was a video exercise program. Resident # 85 was not in front of the television and was not encouraged to participate in the activity. The resident was awake and pulling up her pant legs.</p> <p>During an observation on 2/22/12 at 8:47 a.m., the resident was awake and sitting in her wheelchair in the Dogwood lounge; the television was on but at a very low volume.</p> <p>During an observation on 2/22/12 at 9:19 a.m., the resident was in her wheelchair in the Dogwood lounge in front of the television. Activity assistant # 9 was leading "just dance" from a chair in a seated position. She was not encouraging Resident # 85 to participate. The resident was sitting in her wheelchair playing with her</p>			

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	<p>shirt tail.</p> <p>During a continuous observation on 2/23/12 between 9:41 a.m., and 10:45 a.m., the following was observed:</p> <p>At 9:41 a.m., the resident was in her wheelchair in the Dogwood lounge at the table. At this time, Activity assistant #9 had a group of 5 residents in front of the television leading "just dance". Activity assistant #9 was sitting in a chair. Resident # 85 was not sitting with the group. She was seated behind the group and the activity assistant had her back to the resident. The television sound was at a low level. The resident had her head down and eyes closed. She was not encouraged to participate or spoken to.</p> <p>At 10:06 a.m., the Activity Director came into the lounge and sat on the couch closest to the television and began talking to several residents. Resident # 85 remained in the same location in the lounge at the table with no activity item in front of her and no one had spoken to her.</p> <p>At 10:11 a.m., Activity assistant #9 came into the lounge and had a</p>				

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	<p>conversation with the Activity Director. The Activity Director sat in front of a group of residents in a circle. She began leading the group in exercise. Activity assistant # 9 sat in a chair between two residents. Resident # 85 was still in her wheelchair at the table, behind the group. Neither the Activity Director or the assistant attempted to encourage the resident to participate or spoke to the resident.</p> <p>At 10:18 a.m., Activity assistant #9 gave one resident and the Activity Director a glass of water. Resident # 85 was then taken to the shower room for personal care and returned to the lounge and sat with the group participating in exercise. The Activity Director said hi to the resident and offered her a blanket. She continued to lead the group in exercise, without encouraging Resident # 85 to participate or assist her to participate.</p> <p>At 10:45 a.m., Activity assistant #9 moved the resident from the group to the sofa area where her husband was sitting for a visit. When Resident # 85 saw her husband she stated "there is my Papa."</p> <p>During a continuous observation on 2/23/12 between 12:43 p.m., and 1:45 p.m., the following was</p>			

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	<p>observed:</p> <p>At 12:43 p.m., the resident was brought to the Dogwood lounge and sat in front of the television.</p> <p>Between 1:02 p.m.-1:30 p.m., the resident continued to sit in front of the television. Activity assistant # 9 had 2 residents sitting at the table reading to them. She had her back to Resident # 85 and had not encouraged or brought the resident into the group to listen to the reading.</p> <p>At 1:45 p.m., the resident continued to sit in front of the television, awake and rubbing her hands through her hair and pulling up her pant legs. No staff had spoken to the resident since the beginning of the observation.</p> <p>During observation on 2/24/12 at 9 a.m., Resident # 85 was in her wheelchair in the Dogwood lounge. Activity assistant #9 was assisting the resident to exercise her arms and the resident participated without resistance.</p> <p>The activity participation attendance sheet was reviewed on 2/23/12 at 2:25 p.m., with the Activity Director. She indicated all the highlighted areas, the resident had participated</p>				

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	<p>in. The calendar indicated the resident had attended on 2/2/12, just dance, exercise/coffee club, bible study, and a visitor, On 2/23/12, the calendar indicated the resident attended just dance, exercise/coffee club, storytime and a visitor.</p> <p>During an interview on 2/24/12 at 10:44 a.m., Activity Assistant # 9 indicated Resident # 85 had participated in activities yesterday per the attendance record. When informed the resident was observed not participating, she indicated the resident is "hard to move in her wheelchair." She indicated the resident will move her arms and legs during exercise by herself. She also indicated if attendance activity is highlighted, the resident had participated or has been encouraged to participate.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review, observation and interview, the facility failed to ensure physician orders were followed for pressure ulcer care, anchored catheter care, and administration of medications for 3 of 17 residents reviewed for following physician orders in a sample of 39 (Residents # 69, 8, and 55).</p> <p>Findings included:</p> <p>1. Resident # 69's clinical record was reviewed on 2/22/12 at 2:10 P.M.</p> <p>Resident # 69's diagnoses included, but were not limited to, atrial fibrillation, COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), dysphagia, HTN (hypertension), reflux esophagitis, osteoporosis, and osteoarthritis.</p> <p>A physician's order dated 2/16/12 indicated to admit the resident to hospice.</p> <p>a. The wound assessment completed on 2/22/12 indicated the resident had</p>	F0282	<p>It is the practice of Community Northview Care Center to ensure the services provided by the facility are provided by qualified staff. Resident # 69 Resident # 69 was discharged from the facility on 2-25-2012. All other residents with anchored catheters have the potential to be affected by this alleged deficient practice. All residents with anchored catheters clinical record was reviewed to ensure they had a current, valid physician order for the use of the anchored catheter. The policy for Anchored Catheter Care was revised to include the step to obtain a valid physician's order for the use of the anchored catheter. LPN # 5 was counseled by the Director of Nursing on 3/12/12 regarding the importance of changing dressing timely and as ordered by the physician. DON/Designee will review the clinical record of all residents with an anchored catheter on a monthly basis to ensure the resident has a valid current physician order for the anchored catheter. The results of the monitoring will be reported at the next 2 QAA meetings and the team will then determine the need/frequency for continued</p>	03/28/2012

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	<p>a facility acquired pressure ulcer. This pressure ulcer was assessed as a Stage 3 on her coccyx measuring 3 cm X 1.6 cm x 0.2 cm. The wound progress indicated "bilat legs with less edema since resident is in bed. No open areas along legs. No drainage. No odor." The treatment was "calcium alginate with foam gauze."</p> <p>There was a second wound assessment completed on 2/22/12 which indicated the resident had a facility acquired pressure ulcer. This pressure ulcer was assessed as a Stage 3 on her coccyx measuring 3 cm X 1.6 cm x 0.2 cm. The wound progress indicated "Periwound denuded exstending (sic) 4 cm distally from wound. serous drainage." The treatment was "calcium alginate with foam gauze."</p> <p>February 2012 Treatment record had an order for "Calcium Alginate to coccyx cover with foam dressing q-day." There were initials for 2/20 and 2/21, but none for 2/22. There was an order for "Periguard (a treatment to prevent pressure ulcers) Apply topically to (R) buttocks every shift & as needed."</p> <p>On 2/23/12 at 1:35 P.M., Resident #69 was observed lying on her left</p>		<p>monitoring. RESIDENT # 8 Resident # 8's physician was notified of the instances of the holding of insulin and the resident's weight gain on 3/12/12. All resident's on the Humalog Weight Based/Blood Glucose Control Flow Scale and all residents on the Heart Failure Zone Protocol have the potential to be affected by this alleged deficient practice. The policies for Humalog Weight Based/Blood Glucose Control and Heart Failure Zone Protocol were reviewed. The Director of Nursing (DON)/Designee will review 5 random residents 5 times a week through March, then 3 times a week for 3 months to ensure their insulin is being administered correctly according to the Humalog Weight Based Blood Glucose Scale. Any occurrences of insulin omission will be addressed immediately with the nurse involved and verification of physician notification. The results of the monitoring will be discussed at the next 2 QAA meetings, and provided the insulin is administered as ordered and physician notification is occurring as indicated the monitoring may be discontinued. The Director of Nursing/Designee will review the "Heart Failure Zone Protocol Assessment Forms" for all residents on that protocol to determine that the physician was notified of the resident's weight</p>		

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	<p>side in her bed. She was on an air mattress with an 8 setting. There was a foley bag on the right side of the bed with urine in the bag. LPN #5 was observed providing a dressing change to Resident #69. When the resident's brief was removed by LPN #5, her coccyx area was observed lacking a dressing on the pressure ulcer. LPN #5 indicated there should have been a dressing on the wound and he did not know when it had been removed. There was a pressure ulcer in the center of the crease with 2 smaller pressure ulcers above and below the larger center pressure ulcer. LPN #5 placed Calcium alginate on the central pressure ulcer and not on the 2 smaller pressure ulcers. He then placed the foam dressing over the 2 pressure ulcers. He placed periguard on both of her buttocks.</p> <p>During an interview with LPN #5 on 2/23/12 at 2:37 P.M., he indicated he did not change the dressing yesterday, but had passed on to the second shift that the dressing needed to be changed.</p> <p>b. There was a physician's order dated 11/17/11, which indicated, "Anchor 18 Fr. 30 cc bulb foley catheter for I/O diuresis X 1 week. Monitor I & O. Daily Wts."</p>		<p>gain as indicated per the protocol. This monitoring will be completed 5 x /week through March 2012, then will be completed 3 times a week for 3 months. The results of the monitoring will be discussed at the next 2 QAA meetings, and provided the physician is being notified as indicated per the protocol the monitoring may be discontinued. Licensed Nursing Staff were in-serviced on 3/15/12 to re-educate them on the policies and importance of physician notification. POC Date 3/28/12 Addendum to POC 3-23-2012 The Nurse practitioner was notified the residents insulin was held on 2-21-2012. LPN # 7 was councelled by the DON on 3-12-12 regarding following MD orders for insulin administration.</p>		

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	<p>Resident #69's clinical record indicated an order dated 11/17/11 for "Anchor 18 French 30 cc bulb F/C (foley catheter) for I/O (intake/output) diuresis x 1 week...."</p> <p>The catheter had not been discontinued after one week.</p> <p>The February 2012 Physician's Order lacked an order for the use of the foley catheter.</p> <p>During an interview with RN # 14 on 2/21/12 at 3:07 P.M., she indicated the resident's foley, she believed, was to have been short term, but continued.</p> <p>During an Interview on 2/24/12 at 8:33 AM with LPN #4 she indicated the resident had the foley catheter for edema and she had in place for a while. She indicated she "didn't know it there is an order" for the foley.</p> <p>The policy dated 1/20/09 provided by the ADON on 2/27/12 at 9:45 A.M., for "Anchored Catheter Care" in the procedure lacked the step of needing to have a physician's order to place and continue the use of a foley catheter.</p> <p>2. Resident #8's record was reviewed</p>			
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	<p>on 2/23/12 at 3:05 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus Type II.</p> <p>The physician's rewrite orders, signed 2/8/12, indicated to follow the weight based insulin coverage for the glucometer checks 4 times a day. The physician's order, dated 2/3/12, was a daily weight before breakfast and notify physician if weight more than 2 lbs (pounds) in 1 day or 5 lb over weight.</p> <p>The progress notes indicated the following: On 1/4/12 Called (physician's name) with orders received with no specific order received concerning the insulin withheld and blood sugars.</p> <p>On 1/5/12 at 12:47 p.m., the resident had vomited a large amount of liquid from breakfast earlier; insulin with held with no acute distress noted.</p> <p>On 1/9/12 due to poor appetite insulin withheld at this time with blood sugar of 121.</p> <p>On 1/10/12, resident had a poor appetite eating less than 25% so insulin withheld today; no acute distress noted.</p>			

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	<p>On 1/13/12 at 1:02 p.m., ate 25% of breakfast and lunch and insulin withheld due to poor oral intake. No distress was noted.</p> <p>On 1/14/12 at 8:00 a.m., the resident was indicated to have no signs or symptoms of hypo/hyperglycemia and was only eating 25% of meals on day shift, so insulin was withheld. No information indicated the physician was notified.</p> <p>On 2/7/12 the physician was scheduled to visit; patient is eating better and blood sugar is better with insulin not being held as often.</p> <p>No further information was indicated concerning the physician notification of the withheld insulin.</p> <p>The "HUMALOG WEIGHT BASED/BLOOD GLUCOSE CONTROL FLOW SHEET" scale indicated, but was not limited to, the following:</p> <p>Weight of 90-109 kg (kilogram): Blood glucose (BS): 100-124 = coverage of 1 unit (u); 125-149 = 2 u; 150 - 174 = 3 u; 175 - 199 = 4 u; 200 - 224 = 6 u; 225 - 249 = 7 u; 250 - 274 = 9 u; 275 - 299 = 10 u</p>						

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	<p>Weight of 110-129 kg (kilogram): Blood glucose (BS): 100-124 = coverage of 2 unit (u); 125-149 = 3 u; 150 - 174 = 4 u; 175 - 199 = 6 u; 200 - 224 = 8 u; 225 - 249 = 9 u; 250 - 274 = 11 u; 275 - 299 = 12 u.</p> <p>On 2/23/12 at 4:10 p.m. during an interview, LPN #4 indicated she would follow, for example, with the 1/27/12 weight of 239.2 lb/108.7 kg (kilograms), the 90 to 109 kg "HUMALOG WEIGHT BASED/BLOOD GLUCOSE CONTROL FLOW SHEET" scale would be followed for the insulin coverage.</p> <p>The following was indicated for 1/1 to 1/27/12 insulin based on the weight on 12/30/11 of 256.0/116.4:</p> <p>The 7 a.m. BS's with insulin coverage's held were as follows: 1/9 BS was 121; 1/10 BS - 113; 1/11 BS -115; 1/13 BS 161; 1/15 BS - 145; 1/16 BS - 131;</p> <p>The 11 a.m. BS's with insulin coverage held were as follows: 1/4 and 1/5 both BS's - 195 no coverage; 1/9 BS - 172, 1/10 BS - 198; 1/11 BS - 199, 1/13 BS - 138; 1/14 - BS - 151; 1/12 BS -187 and 1/16 BS - 177 all with no coverage.</p>			

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	<p>On "Comments/Nurse's Notes" of the medication record the following information was indicated related to the insulin withheld:</p> <p>On 1/4 and 1/5, due to vomiting and not eating;</p> <p>On 1/9, nauseated and not eating;</p> <p>On 1/11, 14, 15, 16, and 28 - not eating , n/v on 1/4 and 1/5 and 1/9;</p> <p>On 1/13 - ate only 25%.</p> <p>The resident was in the hospital from 1/19 to 1/27/12.</p> <p>The following was indicated for 1/2012 to 2/3/12 insulin based on the weight on 1/27/12 of 239.2/108.7;</p> <p>The 7 a.m. BS's and insulin coverage held were as follows: On 1/28 - BS - 118; 2/1 - BS - 117; 2/2 - BS 126 all with no coverage;</p> <p>The 11 a.m. BS's: On 2/3 - BS - 114 with no coverage given.</p> <p>The 8 p.m. BS's and insulin coverage were as follows: On 2/2 - BS - 120 with no coverage.</p> <p>The following was indicated for 2/4/12 to 2/22/12 insulin based on the daily weights:</p> <p>The 7 a.m. BS's and insulin coverage</p>			

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	<p>were as follows: On 2/7 - a daily weight of 239.6 lb/108.9 kg; no coverage for the 11 a.m. BS of 201.</p> <p>The "Heart Failure Zone Protocol Assessment Form" indicated the following information: Resident #8's weight gain with no physician notification were as follows: Between 2/6 and 2/7 was a 3 lb weight gain; Between 2/8 and 2/9 was a 2.7 lb weight gain; Between 2/10 and 2/11 was a 2.20 lb weight gain; Between 2/18 and 2/19 was a 4.2 lb weight gain.</p> <p>No further information was indicated related to physician notification.</p> <p>On 2/24/12 at 8:00 a.m. during an interview, LPN #7 indicated Resident #8 was on daily weights. She indicated she would use the resident's daily weights to determine her insulin coverage following the weight based insulin coverage. She also indicated she would wait to see what she eats. She also indicated if she didn't eat after a meal, she would call the physician and report she did not eat and the insulin was held.</p>			
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	<p>On 2/24/12 at 2:00 p.m., LPN #7 indicated the physician notification was placed in the nurse's notes.</p> <p>3. On 2/24/12 at 8:07 a.m. during medication observation, LPN #7 was observed to prepare and administer Resident #55's insulin. At this same time, LPN #7 indicated if the resident's blood sugar had been 80 or below, she would typically hold the insulin.</p> <p>On 2/24/12 at 9:22 a.m., Resident #55's medication sheet was reviewed. The resident's blood sugar was 86 on 2/1/12 at 7 a.m. The medication sheet indicated the resident did not receive his routine insulin due to the Blood Sugar was 86, and he was not hungry. No further information was indicated related to his blood sugar and/or intake.</p> <p>Resident #55's record was reviewed on 2/24/12 at 10:20 a.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetic mellitus.</p> <p>The signed 2/2/12 physician's rewrite orders, originally dated 2/13/09, included, but were not limited to, to give 4 oz coke, orange juice, or resource if the blood sugar (bs) < (is</p>				

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	<p>less than) 60, recheck in 15-30 minutes; accuchecks as needed signs/symptoms of hypo/hyperglycemia and to notify MD if bs > (greater than) 400 or <60. The signed 2/2/12 physician's rewrite orders, originally dated 12/3/10, was accucheck bid (2 times a day) call if <70 or > 350. The Physician order, dated 1/28/11, was to increase the Humulin N insulin to 15 units bid and discontinue all other Humulin N orders.</p> <p>3.1-35(g)(2)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review, observation and interview, the facility failed to provide treatment to promote healing of pressure ulcers for 2 of 3 residents reviewed for pressure ulcers of 6 who met the criteria for having pressure ulcers. (Residents # 96 and # 69).</p> <p>Findings include:</p> <p>1. Resident # 69's clinical record was reviewed on 2/22/12 at 2:10 P.M.</p> <p>Resident # 69's diagnoses included, but were not limited to, atrial fibrillation, COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), dysphagia, HTN (hypertension), reflux esophagitis, osteoporosis, and osteoarthritis.</p> <p>A physician's order dated 2/16/12 indicated to admit the resident to hospice.</p>	F0314	Resident # 69 Resident # 69 was discharged from the facility on 2-25-2012.LPN # 5 was counseled by the Director of Nursing (DON) on 3-12-2012 regarding the importance of completing dressing changes timely as ordered by the physician.Resident # 96 Resident # 96 is routinely treated at the wound center for his pressure area. His treatment was changed on 3/8/12.Currently no residents have an order for a wet-to -dry dressing change.LPN # 12 was counseled and re-in serviced by the ADON regarding her completion of resident # 96's wet-to-dry dressing. All residents with dressing changes have the potential to be affected by this alleged deficient.practice.The policy and procedure for Skin Assessment Prevention and Treatment of Pressure, Non-pressure, and Skin Tears was updated. A new policy was developed for Wet to Dry, and Moist to Dry and MD specific	03/28/2012			

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	<p>The quarterly MDS dated 12/20/2011, indicated the resident had no pressure ulcers.</p> <p>The Braden Scale, dated as completed on 2/21/12, indicated a total score of 12.0, putting the resident at high risk for developing pressure ulcers.</p> <p>The wound assessment completed on 2/8/12 indicated the resident had a facility acquired pressure ulcer which had occurred on 11/29/11. This pressure ulcer was assessed as a Stage 2 on her coccyx measuring 1.5 cm X 1.0 cm x 0.1 cm. The description of the non-pressure wound indicated "coccyx with open area again. pink gran tissue. No drainage. The Wound progress was described as "legs with bilat edema." The treatment was "stoma powder to coccyx. legs- wrap legs off at HS (bedtime) on in A.M. (if pt will let us. refuses most other time.) Spoke with (name of GNP) she is aware."</p> <p>The wound assessment completed on 2/15/12 indicated the resident had a facility acquired pressure ulcer which had occurred on 11/29/11. This pressure ulcer was assessed as a Stage 2 on her coccyx</p>		<p>dressing changes was developed. The ADON/Designee will check all residents with dressings 5 times a week through March, and then 3 times a week through June 30 to ensure the ordered dressing is in place. Any instances of the dressing not being in place will be addressed on the spot by the ADON/Designee and the licensed nurse involved. The results of the monitoring will be discussed at the next 2 QAA meetings and provided resident dressings are in place as ordered on a consistent basis the team will determine the need/frequency for continued monitoring. POC Date: 3/28/12 Addendum to POC 3-23-2012 The DON/Skin care Nurse will inservice all direct care staff regarding the policy and procedure for dressing changes. Documentation will be provided upon return visit.</p>				

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	<p>measuring 1.5 cm X 1.0 cm x 0.1 cm. The description of the non-pressure wound indicated "bilat legs with less edema since resident is in bed. No open areas along legs. No drainage. No odor." The wound progress was "coccyx with pink granulation tissue. No drainage. No odor." The treatment was "stoma powder to coccyx. No wraps on legs because resident refuses."</p> <p>MD Order dated 2/17/2012 for "Calcium alginate to coccyx open area. Cover c (with) foam dressing daily. D/C (discontinue) stoma powder to coccyx."</p> <p>The wound assessment completed on 2/22/12 indicated the resident had a facility acquired pressure ulcer. This pressure ulcer was assessed as a Stage 3 on her coccyx measuring 3 cm X 1.6 cm x 0.2 cm. The wound progress indicated "bilat legs with less edema since resident is in bed. No open areas along legs. No drainage. No odor." The treatment was "calcium alginate with foam gauze."</p> <p>There was a second wound assessment completed on 2/22/12 which indicated the resident had a facility acquired pressure ulcer. This pressure ulcer was assessed as a</p>			

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	<p>Stage 3 on her coccyx measuring 3 cm X 1.6 cm x 0.2 cm. The wound progress indicated "Periwound denuded exstending (sic) 4 cm distally from wound. serous drainage." The treatment was "calcium alginate with foam gauze."</p> <p>February 2012 Treatment record had an order for "Nystatin powder to gluteal crease Q. (every) shift." This was dated 2/9/12 and discontinued on 2/17/12. The treatment was circled as not done 4 times with a notation of "refused." There were 4 times that lacked any initials.</p> <p>February 2012 Treatment record had an order for "Calcium Alginate to coccyx cover with foam dressing q-day." There were initials for 2/20 and 2/21, but none for 2/22. There was an order for "Periguard (a treatment to prevent pressure ulcers) Apply topically to (R) buttocks every shift & as needed."</p> <p>On 2/23/12 at 1:35 P.M., LPN #5 was observed providing a dressing change to Resident #69. When the resident's brief was removed by LPN #5, her coccyx area was observed lacking a dressing on the pressure ulcer. LPN #5 indicated there should have been a dressing on the wound and he did</p>						

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	<p>not know when it had been removed. There was a pressure ulcer in the center of the crease with 2 smaller pressure ulcers above and below the larger center pressure ulcer. LPN #5 placed Calcium alginate on the central pressure ulcer and not on the 2 smaller pressure ulcers. He then placed the foam dressing over the 2 pressure ulcers. He placed periguard on both of her buttocks.</p> <p>During an interview with LPN #5 on 2/23/12 at 2:37 P.M., he indicated he did not change the dressing yesterday, but had passed on to the second shift that the dressing needed to be changed.</p> <p>The care plan for the focus of "The resident has pressure ulcer or potential for pressure ulcer development r/t (related to) disease process, immobility" had interventions, that included, but were not limited to, "...Administer treatments as ordered and monitor for effectiveness.... Follow facility policies for prevention/treatment of skin breakdown.... Calcium alginate to coccyx open area. Cover with foam dressing. Do tx (treatment) daily."</p> <p>The "Policy and Procedure for Skin Assessment: Prevention and</p>			

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	<p>Treatment of Pressure, Non-pressure, and Skin Tears" dated 1/20/09 and provided by the ADON on 2/27/2012 at 9:45 A.M., indicated, "A total body assessment will be completed upon admission or re-admission then weekly times four weeks then with each MDS.... When the unit nurse receives a report of Altered Skin integrity she will assess the area and initiate either a Pressure Ulcer Assessment Form (orange), Alteration in Skin Integrity Form (blue), or the Skin Tear Standard of Care: and with a Physician's order initiate an appropriate treatment.... form will be placed in the communication book for the skin nurse to assess and follow...."</p> <p>2. Resident # 96's record was reviewed on 2/23/12 at 9:00 a.m.</p> <p>Resident # 96's current diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, pneumonia, pressure ulcer stage 4, protein calorie malnutrition, unspecified kidney and ureter disorder, severe sepsis, and a renal mass.</p> <p>Resident # 96 had a current physician order dated 2/16/12 at 2:00 p.m., for wound care for a wet to dry dressing to the pressure area daily (applied</p>			

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	<p>wet, then the dried dressing debrides the wound when removed by pulling away the dead tissue which clings to the dressing).</p> <p>A wound assessment dated 2/22/12, indicated the date of onset for the coccyx wound was 12/7/11. The current 2/22/12 coccyx wound measurements were length 4 centimeters (cm), width 3 centimeters, and depth 2.5 centimeters. The assessment described wound progress with undermining at 4 cm to the bone, minimal sanguinous drainage present, treatment moist saline packed into wound, then cover with abdominal dressing.</p> <p>During an observation of wound care on 2/23/12 at 9:55 a.m., LPN #12 wet the packing in the wound before removing the dressing.</p> <p>During a 2/24/12 at 12:30 p.m., interview with LPN #4, when queried about how to do a wet to dry dressing change, LPN #4 indicated the dressing should be removed dry.</p> <p>During a 2/27/12, 11:10 a.m. interview with the ADON (Assistant Director of Nursing), when questioned about policies for wound care, indicated the</p>			

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	<p>facility did not have a policy for wet to dry dressing.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F0323 SS=C	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review, observation and interview, the facility failed to ensure doors where free from sharp marred surfaces (Resident room doors 203, 204, 202, 201 and the laundry room door) and the facility failed to ensure lancets for Resident # 8 and # 55 were disposed of in a manner to prevent resident access to these sharp item. This deficit practice had the potential to impact 62 of 62 residents residing in the facility.</p> <p>Findings Include:</p> <p>1.) During a 2/23/12, 9:30 a.m., environmental tour accompanied by both the Maintenance Supervisor and the Administrator, the following environmental concerns were noted:</p> <p>a.) The exit door to the laundry room was scuffed and marred and had a rough splintered surface which could result in splinters, injuries or skin tears.</p> <p>b.) Rooms 203, 204, 202, and 201</p>	F0323	<p>It is the policy of CNCC to ensure lancets are disposed of in safe manner and that doors are free from sharp marred surfaces. DOORS Room #s 201, 202, 203, & 204 were sanded by maintenance staff on 2/23/12 to smooth the surface of the door. Maintenance staff checked all resident room doors for scarring and marring. U shaped door edge protector and thick roll sheet door cover was ordered and door edges and surfaces will be covered by maintenance once the product arrives. Administrator and Maintenance staff will complete monthly facility rounds to ensure door safety. The results of these rounds will be discussed at the quarterly QAA meetings. Staff was in-serviced on either 3/14/12 or 3/15/12 regarding the importance of completing a maintenance request if the staff identifies any issues with sharp surfaces on resident accessible doors. LANCETSLPN # 7 was counseled by the Director of Nursing (DON) on 3/12/12 regarding safe and appropriate disposal of lancets. The DON/designee will observe or question 3 licensed nurses</p>	03/28/2012			

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	<p>had marred and scuffed doors, which were splintery and rough to the touch and could result in splinters, injuries or skin tears when contact was made with the surface. During an interview at this time, the Maintenance Supervisor indicated door maintenance was a constant ongoing process due to wheelchairs and machinery making contact with the doors.</p> <p>2. On 2/24/12 at 8:00 a.m., LPN #7 was observed to complete Resident #8's glucometer check. After obtaining the blood specimen for the glucometer with a lancet, LPN #7 was observed to dispose of the lancet in the resident's wastebasket in her room.</p> <p>On 2/24/12 at 8:05 a.m., LPN #7 was observed to complete Resident #55's glucometer check. After completing the glucometer check, LPN #7 was observed to place the lancet in her glove and removed her glove throwing it in the resident's wastebasket.</p> <p>On 2/24/12 at 8:25 a.m. during an interview, LPN #7 indicated because the point of the lancet would retract after the blood test was completed, she would throw the lancet away in the resident's wastebasket.</p>		<p>weekly to ensure proper lancet disposal for 4 months. The results of the observations/interviews will be discussed at the next 2 QAA meetings and provided the nursing staff is disposing of lancets properly the monitoring may be discontinued. Licensed nursing staff was in serviced on either 3/14/12 or 3/15/12 regarding proper lancet disposal.POC: 3/28/12</p>		

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	<p>The "GLUCOMETERS" policy was provided by the Cooperate Consultant on 2/24/12 at 12:20 p.m. This current policy indicated the following:</p> <p>...Policy Statement</p> <p>...Multi box lancets are ordered and supplied at the nurses station to be utilized for patient testing and are disposed of in sharps container after single use....."</p> <p>3.1-45(a)(1)</p>			
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F0329 SS=D	<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 prior non-chemical interventions were attempted prior to administration and ensure proper blood sugar and weight monitoring as ordered for insulin administration, for 2 of 10 residents reviewed for unnecessary medication in a sample of 10. (Resident # 85 and # 8)</p> <p>Findings include:</p>	F0329	Resident # 85 Resident # 85 had no ill effects from her prn Ativan administration. All other residents with prn orders for anti-anxiety medication have the potential to be affected by this alleged deficient practice. The Social Services Director/Designee will review all residents with orders for anti-anxiety medication 3 times a week through June 30 to determine if they have received any prn anti-anxiety medication. In the event a resident received a prn anti-anxiety medication SSD will verify non-pharmacological	03/28/2012

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	<p>1. The record for Resident # 85 was reviewed on 2/23/12 at 8:40 a.m.</p> <p>Current diagnoses included, but were not limited to, dementia, Alzheimer's disease with depression and agitation.</p> <p>Current physician orders indicated an order for Ativan (anti-anxiety medication) 1 milligram to be given twice daily as needed for anxiety.</p> <p>A plan of care dated 8/10/11 indicated the resident used anti-anxiety medications, Ativan for anxiety disorder, pain management and adjustment issues. Approaches to the plan of care included, but were not limited to, monitor and record occurrences of target behavior symptoms and document.</p> <p>The January 2012 and December 2011 Medication Administration Record (MAR) indicated the resident received Ativan on the following date and times with out indication of behaviors or prior interventions for use.</p> <p>January 1 at 7:50 p.m., January 5 (no time), January 28 at 7 p.m., January 29 at 7 p.m., and December 14 at 7 p.m.</p>		<p>interventions were attempted prior to the use of the prn medication. In the event non-pharmacological interventions are not attempted prior to medication administration, the SSD will inform the Director of Nursing so re-education of licensed nurses can take place. The results of the monitoring will discussed at the next 2 QAA meetings and provided the residents are receiving non-pharmacological interventions prior to the use of prn medications the QAA team may determine the monitoring can be discontinued. Resident # 8Resident # 8's physician was notified of the instances of the holding of insulin on 3/12/12. All resident's on the Humalog Weight Based/Blood Glucose Control Flow Scale have the potential to be affected by this alleged deficient practice. The policy for Humalog Weight Based/Blood Glucose Control was reviewed. The Director of Nursing (DON)/Designee will review 5 random residents 5 times a week through March, then 3 times a week for 3 months to ensure their insulin was administered correctly according to the Humalog Weight Based Blood Glucose Scale. Any occurances of insulin omission will be addressed immediately with the nurse involved. The results of the monitoring will be</p>	

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	<p>Additional information was requested from LPN # 2 on 2/24/12 at 9:45 a.m., regarding the behaviors and prior interventions implemented for the use of Ativan on the above dates and times.</p> <p>During interview on 2/24/12 at 10:17 a.m., LPN # 2 indicated she was unable to locate any prior interventions or behavior documentation for the use of the Ativan.</p> <p>A policy titled "Behavior Monitoring/Documentation Policy" was provided by the Social Service Director on 2/22/12 at 4:20 p.m., and deemed as current. The policy indicated: "Purpose: The purpose of the Behavior Monitoring/Documentation Policy is to monitor those patients who exhibit problem behaviors and document those behaviors in an attempt to limit and discourage inappropriate behaviors and improve the quality and quantity of the patients life...."</p> <p>2. Resident #8's record was reviewed on 2/23/12 at 3:05 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus Type II. The physician's rewrite orders, signed</p>		discussed at the next 2 QAA meetings, and provided the insulin is administered as ordered the QAA team will determine the need/frequency for continued monitoring. Licensed nursing staff will be in-serviced by 3/28/12.POC Date: 3/28/12 Addendum to POC-3-23-2012The Don or their designee will review and or observe medication administration on all shifts and at various times to ensure medication is administred correctly.Documentation will be provided upon next visit.				

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	<p>2/8/12, indicated to follow the weight based insulin coverage for the glucometer checks 4 times a day. The physician's order, dated 2/3/12, was a daily weight before breakfast and notify physician if weight more than 2 lbs (pounds) in 1 day or 5 lb over weight.</p> <p>The progress notes indicated the following: On 1/4/12 Called (physician's name) with orders received with no specific order received concerning the insulin withheld and blood sugars.</p> <p>On 1/5/12 at 12:47 p.m., the resident had vomited a large amount of liquid from breakfast earlier; insulin with held with no acute distress noted.</p> <p>On 1/9/12 due to poor appetite insulin withheld at this time with blood sugar of 121.</p> <p>On 1/10/12, resident had a poor appetite eating less than 25% so insulin withheld today; no acute distress noted.</p> <p>On 1/13/12 at 1:02 p.m., ate 25% of breakfast and lunch and insulin withheld due to poor oral intake. No distress was noted.</p>			

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	<p>On 1/14/12 at 8:00 a.m., the resident was indicated to have no signs or symptoms of hypo/hyperglycemia and was only eating 25% of meals on day shift, so insulin was withheld. No information indicated the physician was notified.</p> <p>On 2/7/12 the physician was scheduled to visit; patient is eating better and blood sugar is better with insulin not being held as often.</p> <p>No further information was indicated concerning the physician notification of the withheld insulin.</p> <p>The "HUMALOG WEIGHT BASED/BLOOD GLUCOSE CONTROL FLOW SHEET" scale indicated, but was not limited to, the following:</p> <p>Weight of 90-109 kg (kilogram): Blood glucose (BS): 100-124 = coverage of 1 unit (u); 125-149 = 2 u; 150 - 174 = 3 u; 175 - 199 = 4 u; 200 - 224 = 6 u; 225 - 249 = 7 u; 250 - 274 = 9 u; 275 - 299 = 10 u</p> <p>Weight of 110-129 kg (kilogram): Blood glucose (BS): 100-124 = coverage of 2 unit (u); 125-149 = 3 u; 150 - 174 = 4 u; 175 - 199 = 6 u; 200 - 224 = 8 u; 225 - 249 = 9 u; 250 -</p>						

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	<p>274 = 11 u; 275 - 299 = 12 u.</p> <p>On 2/23/12 at 4:10 p.m. during an interview, LPN #4 indicated she would follow, for example, with the 1/27/12 weight of 239.2 lb/108.7 kg (kilograms), the 90 to 109 kg "HUMALOG WEIGHT BASED/BLOOD GLUCOSE CONTROL FLOW SHEET" scale would be followed for the insulin coverage.</p> <p>The following was indicated for 1/1 to 1/27/12 insulin based on the weight on 12/30/11 of 256.0/116.4:</p> <p>The 7 a.m. BS's with insulin coverage's held were as follows: 1/9 BS was 121; 1/10 BS - 113; 1/11 BS -115; 1/13 BS 161; 1/15 BS - 145; 1/16 BS - 131;</p> <p>The 11 a.m. BS's with insulin coverage held were as follows: 1/4 and 1/5 both BS's - 195 no coverage; 1/9 BS - 172, 1/10 BS - 198; 1/11 BS - 199, 1/13 BS - 138; 1/14 - BS - 151; 1/12 BS -187 and 1/16 BS - 177 all with no coverage.</p> <p>On "Comments/Nurse's Notes" of the medication record the following information was indicated related to the insulin withheld:</p>						

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	<p>On 1/4 and 1/5, due to vomiting and not eating;</p> <p>On 1/9, nauseated and not eating;</p> <p>On 1/11, 14, 15, 16, and 28 - not eating , n/v on 1/4 and 1/5 and 1/9;</p> <p>On 1/13 - ate only 25%.</p> <p>The resident was in the hospital from 1/19 to 1/27/12.</p> <p>The following was indicated for 1/2012 to 2/3/12 insulin based on the weight on 1/27/12 of 239.2/108.7;</p> <p>The 7 a.m. BS's and insulin coverage held were as follows: On 1/28 - BS - 118; 2/1 - BS - 117; 2/2 - BS 126 all with no coverage;</p> <p>The 11 a.m. BS's: On 2/3 - BS - 114 with no coverage given.</p> <p>The 8 p.m. BS's and insulin coverage were as follows: On 2/2 - BS - 120 with no coverage.</p> <p>The following was indicated for 2/4/12 to 2/22/12 insulin based on the daily weights:</p> <p>The 7 a.m. BS's and insulin coverage were as follows: On 2/7 - a daily weight of 239.6 lb/108.9 kg; no coverage for the 11 a.m. BS of 201.</p>			

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	<p>The "Heart Failure Zone Protocol Assessment Form" indicated the following information: Resident #8's weight gain with no physician notification were as follows: Between 2/6 and 2/7 was a 3 lb weight gain; Between 2/8 and 2/9 was a 2.7 lb weight gain; Between 2/10 and 2/11 was a 2.20 lb weight gain; Between 2/18 and 2/19 was a 4.2 lb weight gain.</p> <p>No further information was indicated related to physician notification.</p> <p>On 2/24/12 at 8:00 a.m. during an interview, LPN #7 indicated Resident #8 was on daily weights. She indicated she would use the resident's daily weights to determine her insulin coverage following the weight based insulin coverage. She also indicated she would wait to see what she eats. She also indicated if she didn't eat after a meal, she would call the physician and report she did not eat and the insulin was held.</p> <p>On 2/24/12 at 2:00 p.m., LPN #7 indicated the physician notification was placed in the nurse's notes.</p> <p>On 2/27/12 at 9:55 a.m., ADON</p>			

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	<p>reviewed with her the actual reading of the weight on 2/7 of 239.6 lbs and converted to 108.9 kg which per ADON verified would follow with the 90 to 109 kg which for 7:00 a.m. insulin blood sugar of 158 would indicate insulin coverage of 4 units and not 3 units if following the weight base scale.</p> <p>3.1-48(a)(3)</p>			

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observations, record reviews, and interview, the facility failed to ensure it remained free of a medication error rate of 5 % or greater for 6 of 55 opportunities during 4 of 8 nursing staff observed and for 5 of 13 residents observed during medication pass observation. The medication error rate was 10.9 %. (Resident # 45, 73, 64, 30, 55) (LPN #'s 1, 2, 3, and 4)</p> <p>Findings include:</p> <p>1. On 2/22/12 at 4:09 p.m. during medication pass observation, LPN #1 was observed to prepare and administer Resident #45's eye drops, Genteal eye drops for eye dryness. She was observed to instill 1 eye drop into each eye to complete the eye med administration. On 2/24/12 at 1:30 p.m., Resident #45's medications were reconciled with current physician orders and indicated an order for Genteal eye drops, instill 2 drops to each eye 2 times a day.</p>	F0332	<p>Resident # 45The physician was notified of the medication error regarding resident # 45's Genteal eye drops on 3/14/12.The resident had no ill effects from the incorrect administration of the eye drops.LPN # 1 was counseled by the Director of Nursing (DON) on 3/13/12 regarding her incorrect administration of resident # 45's eye drops.Resident # 55The physician was notified of the medication error regarding resident # 55's inhalers on 3/14/12.Resident # 55's physician was notified of the unavailability of Resident # 55's Nasalcort on 2/23/12. The resident had no ill effects from the incorrect administration of the inhalers or the omission of the Nasalcort.LPN # 4 was counseled by the DON on 3/12/12 regarding her incorrect administration of resident # 55's inhaler.Resident # 30The physician was notified of the incorrect inhaler administration for resident # 30 on 3/14/12. The resident had no ill effects from the incorrect administration of the inhaler.LPN # 4 was counseled by the DON regarding her incorrect inhaler administration on 3/12/12.Resident # 64The physician was notified regarding</p>	03/28/2012

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	<p>2. On 2/23/12 at 8:30 a.m. during medication pass observation, LPN #4 was observed to prepare Resident #55's medications. These medications included, but were not limited to, Advair discus (COPD - chronic obstructive pulmonary disease), Nasalcort Spray (allergies), and Spiriva inhaler (COPD). During this preparation LPN #4 indicated the resident's Nasalcort was unavailable for administration. She checked the EDK (Emergency Drug Kit), which did not contain the Nasalcort spray. She indicated she would check for the supply of the medication after giving the resident his prepared med. Next, LPN #4 proceeded to give Resident #55's prepared medications, which included his 2 respiratory medications. After the resident inhaled the medication from his Advair discus, he was given and administered his Spiriva inhaler with a time span of 1 minute and 25 seconds between the 2 inhalers.</p> <p>On 2/23/12 at 10:10 a.m., Resident #55's medications were reconciled and indicated Advair Diskus 250/50 1 puff 2 times a day, Spiriva inhale contents of 1 capsule every 12 hours, and Nasalcort AQ (Aqueous) Aerosol instill 1 spray in each nostril every a.m.</p>		<p>the incorrect time of resident # 64's medication on 3/15/12. Resident # 64 had no ill effects from the incorrect timing of the physician ordered medication. LPN # 3 was counseled by the DON regarding her incorrect timing of administration on 3/13/12. Resident # 73The physician was notified regarding the incorrect time of resident # 73's medication on 3/14/12. Resident # 73 had no ill effects from the incorrect timing of the physician ordered medication. LPN # 2 was counseled by the DON on 3/13/12 regarding her incorrect timing of the resident's medication. The facility policy regarding medication administration was reviewed and deemed to be current. All residents have the potential to be affected by these alleged deficient practices. The DON/Designee will observe a minimum of 3 inhaler administrations weekly through June 30 to determine correct administration. Additionally the DON/designee will observe 3 random licensed nurses for a minimum of 15 medications passed to determine the timeliness of the medication administration and the correct following of physician orders. These observations will continue through June 30, 2012. The results of the monitoring will be</p>		

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	<p>On 2/23/12 at 10:15 a.m. during an interview, LPN #4 indicated when giving 2 different inhalers, one should wait 2 minutes between the inhalers. She indicated she was still checking on Resident #55's Nasalcort medication availability.</p> <p>On 2/24/12 at 8:37 a.m. during an interview, LPN #4 indicated Resident #55 did not get his Nasalcort medication yesterday as she had worked the day and evening shifts on the same unit.</p> <p>On 2/24/12 at 8:05 a.m. during an interview, LPN #7 indicated Resident #55 had his nasalcort medication today. She indicated she had opened a new bottle today and probably came on the night shift when medications were usually delivered.</p> <p>3. On 2/23/12 at 9:57 a.m., LPN #4 was observed to prepare and administer Resident #30's medication. LPN #4 was observed to give the resident his Advair discus with no instructions given. The resident was observed to barely puff into the advair discus. LPN #4 then gave the resident a small glass of water which he used to rinse out his mouth.</p>		<p>discussed at the next 2 QAA meetings and the team will determine the need/frequency for continued monitoring. Licensed nursing staff was in-serviced regarding proper medication administration on 3/14/12. Additionally, an in-service has been scheduled for 3/20/12 with the consulting nurse from the facility pharmacy. POC Date: 3/28/12 Addendum to POC 3-23-2012 The Don of their designee will review and or observe medication administration on different shifts at different times to ensure proper medication administration. Documentation will be provided upon next visit.</p>	

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	<p>On 2/23/12 at 10:15 a.m. during an interview, LPN #4 indicated one should instruct the resident prior to taking the inhaler to blow out a breath and take a deep breath in before taking the medication.</p> <p>4. On 2/23/12 at 1:37 p.m. during medication pass observation, LPN #3 was observed to prepare and administer Resident #64's medications, which included but were not limited to, Hydralazine (hypertension) 50 milligrams (mg) 1 tablet.</p> <p>On 2/24/12 at 1:30 p.m., Resident #64's medications were reconciled and indicated Hydralazine 50 mg 1 by mouth every 6 hours, scheduled for 12 noon.</p> <p>5. On 2/24/12 at 8:50 a.m. during medication observation, LPN #2 was observed to prepare and administer Resident #73's medications. These medications included, but were not limited to, Misoprostol 200 mg 1 tablet.</p> <p>On 2/24/12 at 1:30 p.m., Resident #73's medications were reconciled and indicated Misoprostol 200 mg 1 by mouth before meals and at bedtime for GERD (gastroesophageal</p>			

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	<p>reflux disease).</p> <p>On 2/24/12 at 2:05 p.m., LPN #2 indicated she knew the medication, Misoprostol, was ordered before meals, but the resident was already in the dining room eating lunch. She indicated she then waited until she was done eating.</p> <p>6. The "MEDICATION TIMES" was provided by the Administrator on 2/21/12 at 11:00 a.m. The times included, but were not limited to, every 6 hours as 12 a.m., 6 a.m., 12 N (noon), and 6 p.m. and before meals as 7 a.m., 11 a.m., and 5 p.m.</p> <p>The "ADMINISTRATION of DRUGS" policy was provided by the Cooperate Consultant on 2/24/12 at 12:20 p.m. This current policy indicated the following:</p> <p>"Residents shall receive their medications on a timely basis and in accordance With (sic) our established policies, of 1 hour prior or 1 hour after assigned time....."</p> <p>The "Ordering and Re-ordering Medications and Treatments" policy was provided by the Cooperate Consultant on 2/24/12 at 12:20 p.m. This current policy indicated the</p>						

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	<p>following:</p> <p>"...As the medication passer (Nurse or QMA) it is your responsibility every time you are passing medications and completing treatments to check and review needed medications and treatment supplies and re-order appropriately.</p> <p>In the event you run out of a medication you must make arrangements to get the medication as soon as possible.</p> <p>Ex: take out of EDK, call pharmacy and arrange for an emergency supply to be delivered as soon as possible....."</p> <p>The "Oral Inhalation Administration" policy was provided by the Cooperate Consultant on 2/24/12 at 12:20 p.m. This current policy indicated the following:</p> <p>"...While inhaling, spray one spray remind resident to hold as long as possible, then exhale. Wait two minutes or manufacturer's instructions before administering the next inhaled medication....."</p> <p>No information was indicated in the 12th Edition of the Geriatric Dosage Handbook and 2010 Nursing Spectrum Drug Handbook concerning</p>			

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	the time span between the 2 inhalers, Advair and Spiriva. 3.1-25(b)(9) 3.1-48(c)(1)				

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F0353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on record review and interview, the facility failed to provide sufficient nursing staffing to meet individual resident needs for 10 of 28 residents who met the criteria for staffing during resident interview in a sample of 28 (Resident 82, 42, 98, 1, 27, 123, 110, 54, 111, and 78) and 1 of 3 residents who met the criteria for sufficient staffing during family interviews in a sample of 3. (Resident # 89)</p> <p>Findings Include:</p>	F0353	<p>The facility has reviewed its staffing ratios along with the input from our Nursing Department (Direct Care staff). It was determined that the critical times for providing care were before, after, and during all meals, and upon rising in the morning and on our Medicare unit. The facility has added a third shift Certified Nursing Assistant to help meet the individual needs of the residents. The facility is also implementing a new program for meal service delivery and pick-up. Our dietary staff will deliver and pick up all room trays to allow the direct care staff to meet the</p>	03/28/2012			

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	<p>Review of Resident Council Minutes for February 2012 contained the following concerns regarding lengthy call light waits:</p> <p>2/13/12-Resident Council Minutes: " 40 min [minutes] for call light" -</p> <p>2/7/12-Resident Council Special Meeting: "Nursing: the call lights still need to get answered quicker but they are trying more now, so it seems."</p> <p>During a 2/23/12, 1:20 p.m., interview, RN #16, indicated she was responsible for scheduling. She indicated the staffing ratio was based on PPDs (Per Patient Day). She additionally indicated PPDs did not take into consideration acuity/ patient level of care needs. The current rate was 4.21.</p> <p>The formula was 4.21 times number of residents equal total number of nursing hours to be staffed. When queried she indicated some workers who do not provide direct patient care were included in the staffing ratio. RN #16 indicated the Admissions Coordinator, the MDS Coordinator, the Care Plan Coordinator and the Ancillary employee all count in the PPD ratio; but they are not scheduled to work the floor and provide direct</p>		<p>resident's needs in a reasonable amount of time. Additionally, a day shift and second shift nurse was added to our schedule on the "Dogwood" side of our facility to assist with the higher acuity of the residents in our facility for rehabilitation. The facility has implemented a weekend manager every weekend. This will be a rotation among several department heads. One of these individuals' responsibilities will be to monitor call lights and interview residents regarding their call light waits. The Administrator/Director of Nursing/Designee will institute weekly checks with 20 different residents to inquire about waiting times for to care to be provided. The results of resident interviews, and weekend manager reports will be reviewed at the next 2 QAA meetings and the QAA team will adjust the plan accordingly. Nursing staff were in-serviced on 3/14/12 regarding the importance of answering call lights timely. POC Date: 3/28/12 Addendum to POC 3-23-2012 In order to ensure residents needs are being met the call light response for residents 82, 42, 98, 1, 27, 123, 110, 54, 111, 78, and 89 will be monitored and documented all shifts at different times during that shift. A record will be kept to include the response time.</p>				

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	<p>services. They can provide direct services, but they are not scheduled to do this task.</p> <p>During resident interviews, with residents who were determined to be interviewable during the stage 1 survey process, the following concerns regarding sufficient staffing to meet resident needs were made:</p> <p>a.) During a 2/21/12, 2:40 p.m., interview with Resident #82, when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #82 responded no. Resident #82 additionally indicated, they are short on the halls during meal times. "I eat in the lounge. I haven't been eating much. In my room, it's hard to get help. I wait 15 minutes."</p> <p>b.) During a 2/22/12, 8:38 a.m., interview with Resident #42 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #42 responded no. Resident #42 additionally indicated, when the resident uses the call light, the resident feels there is a long wait.</p>			

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	<p>"I wait 30 minutes once to twice a month."</p> <p>c.) During a 2/22/12, 9:42 a.m., interview with Resident #98 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #98 responded no.</p> <p>d.) During a 2/21/12, 11:35 a.m., interview with Resident #1 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #1 responded no. Resident #1 indicated, "They don't have enough help. There are too many people to care for; sometimes wait more than 30 minutes. I have been incontinent before I get the urinal."</p> <p>e.) During a 2/21/12, 2:30 p.m., interview with Resident #27 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #27 responded no. Resident #27 also indicated, the facility needed more staff. "I have had to wait periodically on staff. I have</p>						

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	<p>had an accident because had to wait too long."</p> <p>f.) During a 2/22/12, 9:09 a.m., interview with Resident #123 when questioned " o you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #123 responded no. Resident #123 also indicated sometimes the resident waited at night and had waited from 4:30 a.m. until 6:00 a.m. on one occasion.</p> <p>g.) During a 2/22/12, 9:18 a.m., interview, with Resident #110 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #110 responded no. Resident #110 indicated the staff sat around and talk and don't respond to the residents.</p> <p>h.) During a 2/21/12, 2:57 p.m., interview with Resident #54 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #54 indicated the facility could use more help. Long waits occurred a lot of times when</p>			

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	<p>changing shifts.</p> <p>i.) During a 2/21/12, 2:01 p.m., interview with Resident #111 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #110 responded no. Resident #110 indicated the facility needed more aides at night. There was not enough help to get pulled up higher in bed. The CNAs have to go for additional help and this takes a long time.</p> <p>j) During a 2/21/12 , 3:24 p.m., interview with Resident #78 when questioned "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Resident #78 responded no. Resident #78 indicated second shift is often short.</p> <p>k.) During a 2/21/12, 3:00 p.m., interview, with Resident #89's family when quivered "Is there enough staff available in this facility to make sure that residents get the care and assistance they need without having to wait a long time?" Resident #89's family responded no. The family indicated the facility was short staffed</p>			
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	<p>in the evenings.</p> <p>During a 2/24/12, 10:05 a.m. interview, the Administrator indicated PPDs did not change for acuity or resident level of care. He was aware the current acuity level was high.</p> <p>Review of the facility's "Projected P.P.D." records for 2/17/12 through 2/23/12 indicated the facility did not staff to meet their identified P.P.D. rate of 4.21 on the following dates: 2/17/12-4.10 2/18/12-3.98 2/19/12-3.98</p> <p>Review of an untitled facility document, which was provided by Administrator on 2/23/12 at 2:45 p.m., indicated the following: 60 of 62 residents need some type of staff intervention for toileting 50 of 62 residents need some type of staff intervention for eating 50 of 62 residents need some type of staff intervention for bed mobility 46 of 62 residents need some type of staff intervention for ambulation or wheelchair locomotion</p> <p>Review of the 2/21/12, facility completed "Resident Census and Conditions of Residents" indicated the following</p>						

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	<p>43 of 62 residents were occasionally or frequently incontinent of bladder 35 of 62 residents were frequently incontinent of bowel 29 of 62 residents had diagnoses of dementia or a related disorder.</p> <p>3.1-17(a)</p>				

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F0364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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.</p> <p>Based on interview and record review, the facility failed to provide food that was served flavorful and warm in temperatures for 15 of 29 residents (Resident # 124, 82, 125, 42, 98, 21, 30, 96, 27, 110, 61, 54, 55, 59, and 111) who were interviewed during stage 1.</p> <p>Findings include: Review of February 2012, January 2012 and December 2012 Resident council Minutes indicated Residents had expressed dissatisfaction with food taste and temperature all three months.</p> <p>During individual resident interviews, with residents who were determined to be interviewable during the stage 1 survey process, the following concerns regarding food satisfaction were expressed:</p> <p>a.) During a 2/21/12, 2:27 p.m., interview with Resident #124 when questioned: "Does the food taste good and look appetizing?", Resident</p>	F0364	<p>It is the practice of Community Northview Care Center to serve food that is flavorful and warm in temperature. The facility has started to utilize a cart with various condiments, coffee, and hot tea on the cart on each of the unit that is brought down to the unit just prior to the hall cart being delivered. Included on the cart is a microwave, and the assigned staff that pass the hall trays were in serviced to warm the resident's food prior to service and then additionally ask the resident before the staff leaves the room if their food is hot enough. The staff also has hot coffee on the cart and hot water for tea in the event the resident requests these drinks. Facility Dietary Manager and/or Administrator/Designee will attend (by invitation) resident council meetings every month to inquire about food issues. Facility will continue to utilize a form for facility response and corrective action following any concerns voiced in resident council. The administrator/designee and the appropriate department head will discuss any resident concerns and initiate an action plan to</p>	03/28/2012			

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	<p>#124 responded no. Resident #124 indicated room trays were cold and food items were spilled into each other making the meal unappealing.</p> <p>During a 2/21/12, 2:27 p.m., interview with Resident #124 when questioned: "Is the food served at the proper temperature?", Resident #124 responded no.</p> <p>b.) During a 2/21/12, 2:38 p.m., interview with Resident #82 when questioned "Does the food taste good and look appetizing?", Resident #82 responded no. Resident #82 indicated "the food is not seasoned to suit me."</p> <p>When questioned "Is the food served at the proper temperature?", Resident #82 responded no. Resident #82 indicated, "Most of the time it's cold."</p> <p>c.) During a 2/21//12, 3:13 p.m., interview with Resident #125 when questioned, " Is the food served at the proper temperature?" Resident #125 indicated, "Scrambled eggs are barely warm every morning."</p> <p>d.) During a 2/22/12, 8:37 a.m., interview with Resident #42 when questioned "Is the food served at the</p>		<p>address this concern. The results of this action plan will be reported to the resident council president no later than 10 days after the meeting and also follow-up at the next month's council meeting. The facility has implemented a weekend manager every weekend. This will be a rotation among several department heads. One of these individuals' responsibilities will be to monitor meal service and interview resident's regarding the temperature and palatability of their meal. Dietary Manager/Administrator/Designee will interview a minimum of 20 interviewable residents weekly through the end of April 2012, and then 10 interviewable residents weekly through June, 30, 2012 regarding food temperature and palatability. All results of resident interviews will be brought to Administrator for review and any needed actions. The results of the interviews will be discussed at the next 2 QAA meetings and the QAA team will determine the need/frequency of continued monitoring. Family members will continue to be interviewed utilizing QIS food interview questions every other month during customer calls. Upon completion of the every other month customer calls any concerns are reviewed and addressed with the entire management team, and any action plans initiated as</p>				

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	<p>proper temperature?", Resident #42 responded no. Resident #42 indicated food was not warm at supper time.</p> <p>e.) During a 2/22/12, 9:40 a.m., interview with Resident #98 when question "Does the food taste good and look appetizing?", Resident #98 responded no. When questioned, "Is the food served at the proper temperature?" Resident #98 responded no. Resident #98 indicated "Food is sometimes not at the proper temperature, just warm."</p> <p>f.) During a 2/22/12, 8:22 a.m., interview with Resident #21 when questioned "Is the food served at the proper temperature?" Resident #21 responded no. Resident #21 indicated sometimes food was not hot.</p> <p>g.) During a 2/21/12, 3:21 p.m., interview with Resident #30 when questioned "Is the food served at the proper temperature?" Resident #30 responded no. Resident #30 indicated breakfast was cold.</p> <p>h.) During a 2/21/12, 2:37 p.m., interview with Resident #96 when questioned "Does the food taste good and look appetizing?" Resident #96</p>		<p>appropriate. Facility Dietary Manager has developed list of food alternatives that may be requested at all meals. This list has been laminated and placed in all resident rooms. Dietary Manager will inform residents of this list and that they may request any item from this list during her admission interview. Current residents will have list placed in their room by 3/28/12 along with information that they may request any alternative on the list. Staff was in-serviced on either 3/14/12 or 3/15/12 regarding food related concerns. POC Date: 3/28/12</p>	

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	<p>responded no. When questioned "Is the food served at the proper temperature?" Resident #96 responded no. Resident #96 indicated food is neither not nor cold. It's in between.</p> <p>i.) During a 2/21/12, 2:28 p.m., interview with Resident #27 when questioned, "Does the food taste good and look appetizing?" Resident #27 responded no. When question "Is the food served at the proper temperature?", Resident #27 responded no. Resident #27 indicated, the food was usually on chilly side, usually breakfast and lunch.</p> <p>j.) During a 2/22/12, 9:15 a.m., interview, with Resident #110, when questioned "Does the food taste good and look appetizing?", Resident #110 responded no. Resident #110 indicated meat was not done. When questioned "Is the food served at the proper temperature?" Resident #110 responded no.</p> <p>k.) During a 2/21/12 at 2:17 p.m., interview with Resident #61 when questioned "Does the food taste good and look appetizing?" Resident #61 responded no. Resident #61 indicated food doesn't</p>			

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	<p>always taste good."</p> <p>l.) During a 2/21/12, 2:56 p.m., interview with Resident #54 when questioned "Does the food taste good and look appetizing?" Resident #54 responded no. Resident #54 indicated food was not really appetizing</p> <p>m.) During a 2/21/12, 12:06 p.m., interview with Resident #55 when questioned " Is the food served at the proper temperature?", Resident #55 responded no. Resident #55 indicated food was cold every day and every meal. Breakfast was always cold.</p> <p>n.) During a 2/22/12, 9:47 a.m., interview with Resident #59 when questioned "Does the food taste good and look appetizing?", Resident #59 responded no. Resident #59 indicated "I do not like any of the food."</p> <p>o.) During a 2/21/12, 2:00 p.m., interview with Resident #111 when questioned "Is the food served at the proper temperature?" Resident #111 responded no. Resident #111 indicated most of the time the food was cold.</p>			

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	<p>During a 2/23/12, 12:50 p.m., interview, the Food Services Supervisor indicated:</p> <p>There was not a formal method to look at the foods residents leave uneaten to determine if the uneaten food was a result of disaffection with the food item. She indicated the dietary department "keeps an eye on" leftovers but do not document, interview residents about the leftovers or modify menus following their observations.</p> <p>She also indicated she completed a test tray once a week. She indicated she did taste food but didn't document her taste results. She indicated no other employee was assigned to taste testing.</p> <p>She indicated she had not done any quality checks to ensure staff are warming resident food when requested.</p> <p>She indicated all hall test trays were sent with note saying test tray on them. She does no unidentified or surprise trays for testing. She does not complete any action to ensure hall trays are past timely to ensure food temperature was maintained at the proper levels.</p>			

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	<p>Review of the complete test tray records for November 2011 through February 2012, which were provided by the Food Services Supervisor on 2/23/12 at 3:30 p.m., indicated the following:</p> <p>a.) a total of 16 trays were tested during the 4 month period: 9 of 16 test were completed in lunch trays, 4 of 16 were completed for breakfast and 3 of 16 supper.</p> <p>b.) no food tray testing was completed on the weekends.</p> <p>c.) No food tasting was documented.</p> <p>3.1-21(a)(2)</p>			
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F0441 SS=F	<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 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>A. Based on record review, observation and interview, the facility</p>	F0441	The facility has instituted a policy that if 3 residents on either side of	03/28/2012			

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	<p>failed develop and implement a plan to prevent the further spread of infection after the facility identified multiple residents with respiratory infection symptoms. The deficient practice had the potential to impact to 62 of 62 residents residing in the building.</p> <p>B. Based on observations, interviews, and record review, the facility failed to ensure infection control practices were followed related to handwashing/glove use during medication pass for 3 of 8 nursing staff observed during medication pass, cleaning of equipment for 1 of 1 nebulizer observed for 1 of 1 nurse observed, linen handling for 1 of 3 laundry personnel observed in 2 of 3 hallways, and the co-mingling of personal items in residents' rooms for 3 of 40 census sample room observations. (LPN #'S 1, 4, and 6) (Dogwood and Rosewood hallways) (Room #'s 113, 115, and 118) (Resident # 45, 55, 30, 124, 47, 118, 115, 119)</p> <p>Findings include:</p> <p>A1. During an interview on 2/23/12 at 1:00 p.m., the ADON (Assistant</p>		<p>the facility begin to exhibit the same type of infectious symptoms the facility will initiate interventions to prevent/reduce further spread of infection. Depending on the type of infection various interventions could apply. In the event this policy is implemented daily (M-F) conversations will be held with Administrator, Nursing, Dietary and Housekeeping during morning management meeting to determine the facilities daily infection rate. Additionally, all staff will be in-serviced regarding methods to reduce/prevent the spread of infection and housekeeping staff will be instructed on additional cleaning strategies. B1: LPN # 1 was counseled regarding her failure to hand wash for 20 seconds following the instillation of resident # 45's eye drops. B2: LPN # 4 was counseled regarding her failure to hand wash or use sanitizer after picking keys up off the floor, and before she opened up a medication patch for a resident. B3: LPN # 4 was counseled regarding her failure to hand wash or use sanitizer at appropriate times during resident # 30's medication administration. B4: LPN # 6 was counseled regarding her failure to rinse out the nebulizer chamber after Resident # 124 completed their nebulizer treatment. B5: LPN # 6 was observed was counseled regarding her failure to hand</p>		

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	<p>Director of Nursing), who manages the infection control program, indicated:</p> <p>a.) The facility monitors for infections by going through the orders and listing everyone who was on antibiotic therapy and what the antibiotic was used to treat. The facility color coded a map of the facility to indicate the trends and patterns of infections.</p> <p>b.) She also indicated the facility has a current infection rate of 11%, and when it is 15 % she notifies the DON (Director of Nursing).</p> <p>c.) When queried about how often they calculate the infection control rate, she indicated they calculate the infection rate monthly.</p> <p>During an interview on 2/24/12 at 2:00 p.m., with the staff nurses, on all 3 of the halls, Rosewood, Dogwood, and Robin. LPN# 7, LPN# 6, LPN# 3, and LPN#2, indicated there was a total number of 16 residents, either receiving antibiotics for upper respiratory infections (URI) or signs and symptoms of URI, or hospitalized for URI.</p> <p>During an interview with the ADON on 2/24/12 at 12:00 p.m., when queried</p>		<p>wash for a full 20 seconds without a break in the hand washing following the administration of resident # 47's pain pills. B6: Both residents' in Room 118 were given new marked urinals on 2/23/12 following the environmental tour when the issue was brought to the attention of the facility. Both toothbrushes on the shelf in Room 118 were replaced and all personal care items were marked. B7: All items in Room 115 were replaced or marked as appropriate for the resident's. B8: All personal care items were replaced and marked. The measuring container was sanitized, marked, and bagged. B 9: Laundry Aide # 10 was in-serviced regarding proper linen handling by the Laundry Supervisor 3/15/12. The Laundry Supervisor completed an in-service with all laundry staff 3/15/12. All staff was in-serviced on either 3/14/12 or 3/15/12 regarding hand-washing per policy and procedure, linen handling, appropriate storage of personal items, and infection control practices. The ADON/Designee will monitor staff hand washing 5 random staff weekly through the end of June to monitor for proper hand washing and linen handling. The results of the hand washing/linen handling monitoring will be discussed at the next 2 QAA meetings and the need for further monitoring will be discussed and determined by the</p>				

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	<p>about when inservices are done related to the reports,and current infections, she indicated that they have had no inservices this month except for new employees.</p> <p>When queried regarding the 16 residents with signs and symptoms of a URI and the infection rate of 11% to determine if the facility had developed and implemented a plan to prevent/reduce future spread of infection, the ADON indicated the facility had not implemented any plan to prevent further spread of infection.</p> <p>A2. During an observation on 2/24/12 at 10:40 a.m., the Care Plan Coordinator, was observed at the Dogwood nursing station coughing, covering her mouth with her hand. She then completed documentation in a chart, closed the chart and placed it back in the chart rack. She took another chart, coughed without covering her mouth, continued to chart, closed the chart and returned it to the chart rack and went to her office. No hand washing or sanitizing was observed.</p> <p>A3. During an interview on 2/24/12 at 10:51 a.m., housekeeper # 7 indicated he had not been instructed to increase or change his cleaning and sanitizing of resident rooms,</p>		<p>QAA team. Additionally, other components of the infection control program will continue to be reviewed on a quarterly basis. POC Date: 3/28/12 Addendum to POC 3-23-2012The Don or their designee will monitor on all shifts at different times during that shift to include all staff.</p>		

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	<p>hallways, or common areas.</p> <p>A4. A current policy received from the ADON on 2/24/12 at 11:30 a.m., titled Infection Control Program. Indicated " ...will maintain an infection control program in order to investigate,control and prevent infections within the facility...infection control program will monitor and investigate causes of infection and the manner of spread....all data will be reviewed at least quarterly"</p> <p>B1. On 2/22/12 at 4:09 p.m. during medication pass, LPN #1 with gloved hands was observed to give Resident #45 her eye drop medication. After returning the eye drop container to its bag, she removed her gloves and was observed to handwash for less than 15 seconds. She then returned to the medication cart and put the</p>				

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	<p>medication away.</p> <p>B2. On 2/23/12 at 8:30 a.m. during medication pass, LPN #4 with gloved hands was observed to remove Resident #55's medication patch from his back, removed her gloves disposing of them into the wastebasket. She then indicated she needed a pair of scissors to open the new medication patch as she searched first in her uniform pocket. She then walked out in the hallway to the medication cart and checked the drawers for a pair of scissors. As she returned to the nurse's station, she checked both treatment carts in the hallway. She was then given a pair of scissors by LPN #3. As LPN #4 returned to the medication cart, she dropped her medication cart keys on the floor and picked them up off of the floor. At the medication cart LPN #4 was observed to cut open the medication patch package with cleansed scissors before handgel was observed used. LPN #4 then returned to the room and applied the medication patch to the resident.</p> <p>B3. On 2/23/12 at 10:15 a.m. during medication pass, LPN #4 was observed to assist Resident #30 with rinsing his mouth out after the Advair inhalation was given by holding the</p>				

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	<p>cup the resident spit the water back into after rinsing his mouth. No handwashing was observed as she donned a pair of gloves and proceeded to administer the resident's eye drops. After completing the second mouth rinse after an inhaler administration, LPN #4 with her gloved hands took the second cup used for his mouth rinse, his medication water cup with water left in it, and the 2 respiratory medications and the bagged eye medication out to the medication cart. She then with same gloved hands threw the water cups away and put the 3 medications back into the medication cart drawers before removing her gloves and using handgel.</p> <p>B4. On 2/23/12 at 12:43 p.m. during medication pass, LPN #6 was observed to complete Resident #124 's nebulizer treatment. LPN #6 then proceeded to remove the medication container from the nebulizer and rinsed and dried it out with paper towels in the bathroom. She then reconnected it to the mask and put it in the bag at the bedside.</p> <p>On 2/24/12 at 2:00 p.m. during an interview, the MDS (Minimum Data Set) nurse and the ADON (Assistant</p>						

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	<p>Director of Nursing) both indicated the nebulizer mask and tubing were changed 2 times a week with no need to rinse the mask and/or the medication container after use.</p> <p>B5. On 2/23/12 at 1:06 p.m. during medication pass, LPN #6 was observed to administer Resident #47 his pain pills. She then was observed to handwash for 15 seconds, then reapplied soap from the dispenser and handwashed for 10 more seconds only.</p> <p>B6. On 2/21/12 at 12:20 p.m. during Room #118's observation, the unmarked items of a soap dish, 2 toothbrushes, a tube of toothbrush on the shelf above the sink and 2 unmarked bagged urinals on the back of the toilet tank were observed in the bathroom. At this same time during an interview with Resident #55, he indicated the unmarked urinals in the bathroom was a problem to know which urinal was his or his roommates. The 2 residents of this room were observed present in the room at this time.</p> <p>On 2/21/12 at 12:22 p.m. during an interview, CNA #13 indicated she would not know for sure which urinal belong to which resident.</p>			

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	<p>On 2/22/12 at 9:46 a.m. in Room #118's bathroom, the unmarked items of a soap dish, 2 toothbrushes, a tube of toothbrush were observed on the shelf above the sink.</p> <p>On 2/23/12 at 8:07 a.m. in Room #118's bathroom, a large bottle of mouthwash, a large bottle of body powder, 2 toothbrushes, a large tube of toothpaste, and 1 open soap dish containing 2 slivers of soap were observed unmarked and on the shelf in the bathroom</p> <p>B7. On 2/21/12 at 12:42 p.m. during Room #115's observation, a dull/gray handkerchief with brown spots scattered over it, unmarked razor, unmarked shaving cream and unmarked comb were observed on the bathroom shelf. Also, a black cloth/brace was observed behind the toilet in the corner of the bathroom. One of the resident's residing in this room was not present at the time of this observation.</p> <p>B8. On 2/21/12 at 3:07 p.m. during Room #119's observation, the unmarked items of a plastic cup containing 2 slivers of soap, a toothbrush, and a tube of toothpaste were observed on the shelf above the</p>			

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	<p>sink in the bathroom. Also, an uncovered measuring container was observed on the toilet tank. Two residents were observed in this room at this same time.</p> <p>B9. On 2/22/12 at 8:50 a.m., Laundry Aide #10 was observed passing personal linen from room to room with the personal linen touching/next to her uniform down Rosewood hallway. Also, the personal clothing was hanging on an uncovered rack as she proceeded down the hallway. At this same time during an interview, Laundry Aide #10 indicated she should have the cart covered while passing the linen, and it should not be touching her uniform</p> <p>On 2/24/12 at 8:30 a.m., Laundry Aide #10 was observed passing personal linen down the Rosewood hallway. A sheet was observed folded on the top of this cart but not covering the hanging personal linen as she was passing the personal linen from room to room.</p> <p>On 2/24 at 11:15 a.m. on Dogwood hallway, a pile of linen was observed on the shower room floor by the sink. No one was observed in this shower room with the light of this shower room turned off.</p>						

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	3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(l) 3.1-19(g)			

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F0490 SS=F	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to have policies to address care areas for 17 of 17 residents who were reviewed for the care areas of pressure ulcers, foley catheter use, nebulizer treatments. This deficient practice had the potential to impact 62 of 62 residents residing in the building.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The policy for "Anchored Catheter Care" dated 1/20/09 lacked the step of getting a physician's order for the catheter use. <p>During an interview with RN #15 on 2/27/12 at 10:52 A.M., she indicated, "We don't have a policy for the getting a doctor's order for the use of the foley catheter."</p> <ol style="list-style-type: none"> The policy for "Prevention and Treatment of Pressure, Non-pressure, and Skin Tears dated 1/20/09 lacked information on calling the doctor for treatment options for different stages 	F0490	<p>It is the policy of Community Northview Care Center to have policies to address care areas for pressure ulcers, foley catheter use, and nebulizer treatments. The policy for "Anchored Catheter Care" dated 1/20/09 was revised to include obtaining a physician's order. The policy for "Prevention and Treatment of Pressure, Non-pressure, and Skin Tears was reviewed and completely updated by the ADON/wound nurse. The policy now includes steps for calling the doctor for treatment options for different stages of pressure ulcers. A policy titled "Policy and Procedure for Nebulizer Treatments:" was updated to include what type of assessment would be completed before and after the treatment, and the steps to clean the equipment after use. All licensed nursing staff will be inserviced by 3/28/12 on the aforementioned policy revisions. POC Date: 3/28/12 Addendum to POC 3-23-2012 This deficiency will be monitored Quarterly or as needed when a concern arises regarding a situation that requires reviewing a policy for a certain</p>	03/28/2012	

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	<p>of pressure ulcers.</p> <p>During an interview with RN #15 on 2/27/12 at 10:52 AM., she indicated, "We don't have a policy for calling the doctor and getting a treatment for pressure ulcers. The nurses just know what to do."</p> <p>3. A policy titled "Policy and Procedure for Nebulizer Treatments:" was provided by the Corporate Consultant on 2/24/12 at 12:20 p.m., and deemed as current. The policy lacked what type of assessment would be completed before and after the treatment, and the steps to clean the equipment after use.</p> <p>3.1-13(j)</p>		<p>situation. Our QAA team will help to determine the issues at hand and will review those policies during that process. The facility will continue to review all tags at our QA until the next survey. This will keep us current on the need for education and traing of our staff for compliance.</p>		

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F0520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify and implement a plan of action for the identified concerns of food not being served at an acceptable temperature, infection control, and treatments being in place. This deficient practice had the potential to affect 62 of 62 residents residing in the building.</p> <p>Findings include:</p>	F0520	<p>Since all residents have the potential to be affected by this deficient practice, the facility has implemented a plan of action for food not being served at an acceptable temperature, infection control and treatments being in place. The report states that our QAA meets on a monthly basis; however, the committee meets on a quarterly basis. The facility department heads complete customer calls every other month to resident's who are interviewable and family</p>	03/28/2012			

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	<p>During an interview with the administrator on 2/27/12 at 9:30 A.M., he indicated the QAA committee met on a monthly basis and the concerns were discussed then with a plan put into place.</p> <p>The Administrator indicated the facility had put the carts with the microwaves in place in the hallways about 1 and 1/2 weeks ago, due to the complaints of the residents about the cold food. During the stage 1 interviews, 15 residents complained the food was not served at the proper temperature and was not flavorful.</p> <p>He indicated the facility was aware of the infections and had been reporting at the daily meeting on the residents who were ill. He said the infection control nurse was in charge of the infection control and she would report at the QAA meeting. The plan done by the infection control nurse lacked inservicing and monitoring the staff on methods to prevent the spread of infections. The facility had a current infection rate of 11 % for respiratory infections.</p> <p>He indicated the treatments for pressure ulcers should have been discovered earlier by the wound nurse. He indicated this was</p>		<p>members of non-interviewable residents to inquire regarding care and services. The facility has implemented a QAA referral form for those items addressed requiring improvement for the next meeting. Any concerns from the resident council meetings will also be added to this form to be addressed at the next QAA meeting. The Administrator/Designee will review any concerns from the customer call interviews or resident council meetings to ensure any concerns are addressed timely. The facility has implemented a weekend manager every weekend. This will be a rotation among several department heads. One of these individuals' responsibilities will be to monitor meal service and interview residents regarding the temperature and palatability of their meal. Dietary Manager/Administrator/Designee will interview a minimum of 20 interviewable residents weekly through the end of April 2012, then 10 interviewable residents weekly through June 30, 2012 regarding food temperature and palatability. All results of resident interviews will be brought to the Administrator for review and any needed actions. The facility infection control program policy was revised. The policy now includes information regarding staff in-servicing and</p>		

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	<p>reviewed in the QAA meeting. He did not have a plan of action for the treatment of pressure ulcers. During the survey, dressing changes were not completed as ordered and interventions to promote healing were not implemented.</p> <p>3.1-52(b)(2)</p>		<p>other interventions to prevent/reduce the spread of infection. The ADON/Designee will monitor staff hand washing of 5 random staff weekly through the end of June to monitor for proper hand washing and linen handling. The policy and procedure for Skin Assessment Prevention and Treatment of Pressure, Non-pressure, and Skin Tears was updated. A new policy was developed for Wet to Dry, and Moist to Dry and MD specific dressing changes was developed. The ADON/Designee will check all residents with dressings 5 times a week through March, and then 3 times a week through June 30 to ensure the ordered dressing is in place. Any instances of the dressing not being in place will be addressed on the spot by the ADON/Designee and the licensed nurse involved. The results of the monitoring and interviews will be discussed at the next 2 QAA meetings and provided resident dressings are in place as ordered on a consistent basis, food is served to the residents at appropriate temperature, and infection control practices are being followed by the staff, the team may determine the need/frequency for continued monitoring. POC Date: 3/28/12 Addendum to POC 3-23-2012 The above monitoring will include monitoring on all 3 shifts at</p>	

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			different times during those shifts to ensure compliance. This will be the responsibility of the DON or their designee. Documentation will be provided upon return.	