

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
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NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00199941.</p> <p>Complaint IN00199941 - Substantiated. Federal/State deficiencies related to the allegations are cited at F371</p> <p>Survey dates: May 25, 26, 27, 31, and June 1, and 2, 2016.</p> <p>Facility number: 000497 Provider number: 155606 AIM number: 100291530</p> <p>Census bed type: SNF/NF: 97 Total: 97</p> <p>Census payor type: Medicare: 19 Medicaid: 48 Other: 30 Total: 97</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 6/6/16 by</p>	F 0000	<p>This Plan of correction is submitted under Federal and State regulations and status applicable to long term care providers This plan of correction does not constitute an admission of liability and such liability hereby denied The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the are cited correctly Please accept this plan as our credible allegation of compliance Westside Village Health Center respectfully requests paper compliance for this survey</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>29479.</p> <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</p>				

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	<p>the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician and POA (Power of Attorney) were notified timely when a change in skin condition was identified for 1 of 4 residents reviewed for notification of change in condition (Resident #75).</p> <p>Finding includes:</p> <p>Resident #75's POA indicated during an interview on 5/27/16 at 10:31 a.m. that on 5/21/16 he saw a dressing on Resident #75's right ankle with a date of 5/12/16 written on it. The facility had not notified the POA of an open area on the resident's ankle.</p> <p>The record for Resident #75 was reviewed on 5/31/16 at 3:20 p.m. Diagnoses included, but were not limited to, joint disorder right ankle and foot, and pressure ulcer sacral region.</p> <p>A progress note, dated 5/23/16, indicated the POA was notified of a new area on Resident #75's right ankle including the interventions and lab work requested. The record did not indicate the POA was contacted about the area prior to this date.</p>	F 0157	<p>1. Resident#75 family was updated with plan of care by MD and DON on 5/23/16.</p> <p>2. Other residents with any Change of Condition have the potential to be effected, therefore a 100% audit will be completed for family and MD notification of recent Change in Condition by 7/2/16.</p> <p>3. The SDC or designee will in-service licensed nursing staff Change of Condition and MD and Family Notification. In-serving to be completed by 7/2/16.</p> <p>4. Nursing administration to audit Change of Condition for MD and family notification. Audits will be completed daily for 30-days, then weekly for 30 days then monthly for 90-days. Results will be presented to PI monthly. PI to determine the need for further audits.</p> <p>5. Date of compliance 7/2/16.</p>	07/02/2016			

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	<p>The Progress Notes did not indicate any open area on to the right outer ankle until the documentation on 5/23/16.</p> <p>The May, 2016, Recapitulation of Physician's Orders did not indicate a treatment order was obtained from the physician until 5/23/16 which was to cleanse the right ankle area with normal saline, pat dry and apply a dry ABD (large abdominal) pad and secure with kerlix (long gauze strip used to wrap around and hold a dressing in place) and to change it daily and as needed.</p> <p>A Physician's Note, dated 5/23/16, indicated the resident had a new open area on her right ankle which had been noted by the nursing staff on 5/12/16 and it was brought to the physician's attention on 5/23/16. The Physician's Note indicated there was some erythema (redness or rash) on the right lateral (side) of the right ankle with 4 areas 3-4 millimeters, shallow ulcers with good granulation.</p> <p>A "Comment & Concern Form" was provided by the DON (Director of Nursing) on 6/1/16 at 10:00 a.m. The form indicated on 5/23/16 the POA had informed her of a dressing which had been placed on Resident #75's ankle on 5/12/16 and was still in place on 5/21/16.</p>			

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	<p>During an interview with the Wound Nurse on 6/1/16 9:30 a.m., she indicated she wasn't aware of the area on the ankle until the POA voiced a concern to the DON on 5/23/16. She indicated It was an area that opens, heals, and reopens.</p> <p>During an interview on 6/1/16 at 9:40 a.m. the ADON (Assistant Director of Nursing) indicated the wound had the appearance of an abscess when first assessed on 5/23/16.</p> <p>During an interview on 6/1/16 at 10:30 a.m. the DON indicated Resident # 75's POA discovered a dressing on the resident's right ankle during the weekend of 5/21-22/2016 that was dated 5/12/16. The DON indicated the facility began investigating what happened to necessitate a dressing to the area and learned LPN #19 discovered an open area during the night shift on 5/12/16 and did not consult with the physician regarding treatment orders. The LPN covered the area with a dressing and indicated she had reported the skin condition to LPN #2 when she ended her shift. LPN #2 denied awareness of the skin condition and the 24 hour report did not indicate a change in condition.</p> <p>On 6/1/16 11:05 a.m., LPN #2 indicated</p>			

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	<p>the night nurse said nothing to her about putting a dressing on Resident #75's ankle.</p> <p>On 6/2/16 9:55 a.m. the DON indicated she was informed on May 23, 2016 Resident #75 ' s POA took pictures of a dressing on the resident ' s right ankle that had a date of 5/12/16. The DON indicated LPN #19 called her to inform her of the POA ' s concern regarding an open area, but she did not know the area the LPN was referring to was a new open area on the resident ' s ankle.</p> <p>During an interview with the DON on 6/2/16 at 11:05 a.m. she indicated the nurse who discovered the wound should have called the doctor to obtain a treatment order. She should have completed a change in condition form and SBAR form (Situation Background Appearance Review) and notified the family.</p> <p>A current facility policy, undated, titled "Changes in Resident's Condition or Status" was provided by the DON on 6/2/16 at 8:50 a.m. The policy indicated: "The facility will notify the resident, his/her attending physician, and representative (sponsor) of changes in the resident's condition and/or status.... Procedure 1. Nursing services will be responsible for notifying the resident's</p>			

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F 0241 SS=D Bldg. 00	<p>attending physician when:...b. There is a significant change in the resident's physical, mental, or emotional status...2. Nursing services will be responsible for notifying the resident, his/her next of kin, representative (sponsor) as each case may apply, when:...b. There is a significant change in the resident's physical, mental, or emotional status...4. All notifications will be made as soon as practical, but in no case will such notification exceed twenty-four (24) hours. 5. All changes in the resident's medical condition must be properly recorded in the resident's medical record...."</p> <p>3.1-5(a)(2)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure staff conversations respected a resident's dignity for 1 of 1 resident reviewed for</p>	F 0241	<p>1.Resident# 105 has since expired. 2.Residentsadmitted to the facility have the potential to be effected, therefore residentsin</p>	07/02/2016

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	<p>dignity (Resident #105).</p> <p>Finding includes:</p> <p>During a observation of dining on 5/25/2016 from 12:36 p.m. to 1:01 p.m., certified nurse assistant (CNA) #3 assisted Resident # 105 with lunch. The resident was seated in a was sitting in a Broda chair (specialized high back wheelchair), and leaning to the right with head down and chin close to his chest. The CNA in a loud volume, "Is he always like this? How am I gonna (sic) do this?" The question was directing to 2 CNA's at the next table. CNA #4 and CNA #5. CNA #3 was able to be heard clearly from two tables over. CNA #4 responded from the next table, "He's always like that." CNA #3 repositioned the Resident and sat next to him, then asked in a loud voice, "How do I pull him up, or what?" Another CNA assisted with repositioning and asked, " Is that any better? Nope, doesn't look like it." CNA #3 sat next to the resident and asked again , "How am I gonna (sic) do this?" CNA #5 answered from the next table, "You got to get up under there." CNA #3 attempted to feed the resident but the resident did not open his mouth. The CNA asked, "Does he even eat?" She Stated, "He's not even opening his mouth. He wont wake up." The CNA moved from Resident #105's</p>		<p>specialized wheelchairs will be screened by therapy for positioning andthose residents care guides will be updated with changes.</p> <p>3.The SDCor designee will in-service staff Dignity and Residents Rights. In-serving tobe completed by 7/2/16.</p> <p>4.Nursingadministration to monitor meal service daily times 90 days. Results will bepresented to PI monthly. PI to determine the need for further audits.</p> <p>5.Date ofcompliance 7/2/16.</p>	

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	<p>side and assisted other residents with meals. She returned to resident #105's table but did not offer food. Other residents and visitors were present in the dinning room while conversations were conducted across tables regarding Resident #105's ability to eat and his positioning.</p> <p>During an interview on 6/01/2016 at 11:24 a.m., the Director of Nursing (DON) indicated staff should not have discussed a resident's care in presence of other residents or visitors. Staff should have ensured a private location to seek clarification of resident care.</p> <p>During an interview on 6/02/2016 at 11:01 a.m., License Practical Nurse (LPN) #6 indicated conversations regarding residents should be private.</p> <p>A current policy titled "Resident Rights," received from the DON on 6/1/16 at 12:10 p.m., indicated, "...A resident is treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs...."</p> <p>3.1-3(t)</p>			

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a new open area was assessed and treatment orders received and followed immediately after discovery of the area for 1 of 4 residents reviewed for open areas and assessments (Resident #75)</p> <p>Findings include:</p> <p>The record for Resident #75 was reviewed on 5/31/16 at 3:20 p.m. Diagnoses included, but were not limited to, joint disorder right ankle and foot, and pressure ulcer sacral region.</p> <p>A "Comment & Concern Form" was provided by the DON (Director of Nursing) on 6/1/16 at 10:00 a.m. The form indicated on 5/23/16 the POA had informed her of a dressing which had</p>	F 0309	<p>1.Skinassessment was completed on Resident 75# and a treatment was obtained on5/23/16 and the sheet was placed in residents #75 chart.</p> <p>2.Residentswho receives weekly skin assessments have the potential to be effected,therefore those residents will have a 100% audit for the Weekly Skin Assessmentsheet. Audits to be completed by 7/2/16.</p> <p>3.The SDCor designee will in-service licensed nursing staff on Medical Records Keepingand Skin Assessments. In-serving to becompleted by 7/2/16.</p> <p>4.Nursingadministration to audit Weekly Skin Assessment Sheets. Audits will be completeddaily for 30-days, then weekly for 90-days, then monthly. Results will bepresented to PI monthly. PI to determine the need for further audits.</p>	07/02/2016
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	<p>been placed on Resident #75's ankle on 5/12/16 and was still in place on 5/21/16.</p> <p>The Nursing Progress Notes did not indicate any open area on the right outer ankle until the documentation on 5/23/16.</p> <p>The record did not include documentation in regard to a description of the wound, including measurements.</p> <p>The May, 2016, Recapitulation of Physician's Orders did not indicate a treatment order was obtained from the physician until 5/23/16 which was to cleanse the right ankle area with normal saline, pat dry and apply a dry ABD (large abdominal) pad and secure with kerlix (long gauze strip used to wrap around and hold a dressing in place) and to change it daily and as needed.</p> <p>A Physician's Note, dated 5/23/16, indicated the resident had a new open area on her right ankle which had been noted by the nursing staff on 5/12/16 and it was brought to the physician's attention on 5/23/16. The Physician's Note indicated there was some erythema (redness or rash) on the right lateral (side) of the right ankle with 4 areas 3-4 millimeters, shallow ulcers with good granulation.</p>			

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	<p>The right ankle wound dressing change was observed on 6/1/16 at 9:30 a.m. The wound was approximately 1 - 1.5 centimeters, circular in shape, moist, with granulation tissue appearance. The surrounding skin was pink, intact, and did have 3 small scabbed areas 2 millimeters in length present below the open area.</p> <p>During an interview with the Wound Nurse on 6/1/16 9:30 a.m., she indicated she wasn't aware of the area on the ankle until the POA voiced a concern to the DON on 5/23/16. She indicated It was an area that opens, heals, and reopens.</p> <p>During an interview on 6/1/16 at 9:40 a.m. the ADON (Assistant Director of Nursing) indicated the wound had the appearance of an abscess when first assessed on 5/23/16.</p> <p>During an interview on 6/1/16 at 10:30 a.m. the DON indicated Resident # 75's POA discovered a dressing on the resident's right ankle during the weekend of 5/21-22/2016 that was dated 5/12/16. The DON indicated the facility began investigating what happened to necessitate a dressing to the area and learned LPN #19 discovered an open area during the night shift on 5/12/16 and did not consult with the physician regarding</p>			

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F 0333 SS=D Bldg. 00	<p>treatment orders. The LPN covered the area with a dressing and indicated she had reported the skin condition to LPN #2 when she ended her shift. LPN #2 denied awareness of the skin condition and the 24 hour report did not indicate a change in condition.</p> <p>On 6/1/16 at 11:05 a.m. during an interview with LPN #2, she indicated the night nurse said nothing to her about putting a dressing on Resident #75's ankle. She also indicated the nurses do their weekly skin assessments on shower days and the CNAs also check on skin during showers.</p> <p>During an interview on 6/1/16 at 11:40 a.m. the DON indicated she was unable to provide the weekly skin assessment sheets for Resident #75 because they were missing.</p> <p>3.1-37(a)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, interview, and</p>	F 0333	1.MD andresident notified of	07/02/2016

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	<p>record review, the facility failed to ensure a diuretic (water pill) was given as prescribed for 1 of 5 residents reviewed for medication administration (Resident #90).</p> <p>Finding includes:</p> <p>During observation of medication administration on 6/2/16 at 9:55 a.m., Licensed Practical Nurse (LPN) #1 prepared Resident #90's medications including, but not limited to, one tablet of torsemide (diuretic) 10 milligrams (mg). Resident #90 told LPN #1 the medication cup only contained one torsemide tablet and indicated she should receive three toresmide tablets. LPN #1 confirmed there was one tablet of toresmide 10 mg in the medication cup. Resident #90 indicated she only received 10 mg of the diuretic the day before and had gained five pounds (lbs) in three days.</p> <p>On 6/2/16 at 12:34 p.m., Resident #90's record was reviewed. Diagnosis included, but was not limited to congestive heart failure. The annual Minimum Data Set (MDS) assessment, dated 5/16/16, indicated Resident #90 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and was cognitively intact. The MDS indicated Resident #90 had taken a diuretic every day of the</p>		<p>medication error. Order received to give one time order to correct the medicationerror.</p> <p>2.Nurse#1 was educated on the medication error.</p> <p>3.The SDCor designee will in-service licensed nursing staff on Medication Administration.In-serving to be completed by 7/2/16.</p> <p>4.Nursingadministration to audit 5 licensed staff members during medicationadministration daily for 30-days, then weekly for 30 days then monthly. Resultswill be presented to PI monthly. PI to determine the need for further audits.</p>	

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	<p>seven day assessment.</p> <p>The physician's order, dated 4/1/16, indicated Resident #90 was prescribed 3 torsemide 10 mg tablets (30 mg daily) orally daily.</p> <p>The Treatment Administration Record (TAR) for May 2016 indicated Resident #90 weighed 274 lbs on 5/30/16. The weight history, dated 6/1/16, indicated Resident #90 weighed 279 lbs.</p> <p>During an interview on 6/2/16 at 12:09 p.m., the Director of Nursing (DON) indicated LPN #1 administered 10 mg of torsemide and should have administered the ordered dose of 30 mg to Resident #90.</p> <p>On 6/2/16 at 12:09 p.m., the DON provided the current Medication Administration policy. The policy indicated, "...All medications are administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis....Responsibility of the nursing professional: be aware of the classification, action, correct dosage, and side effects of a medication before administration...Check Medication Administration Record (MAR)...Read each order entirely...Remove medication</p>				

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F 0371 SS=E Bldg. 00	<p>from drawer. Read label three times...When removing from drawer...Before pouring...After pouring...."</p> <p>3.1-48(c)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was served, prepared, and stored under sanitary conditions for 1 of 1 dining observation and 2 of 2 kitchen observations, and 3 of 5 nutrition refrigerators reviewed for monitoring of temperatures.</p> <p>Findings include:</p> <p>1. During a observation of dining on 5/25/2016 from 12:36 p.m. to 1:01 p.m., Certified Nursing Assistant (CNA) #5 assisted Residents #7 and Resident #63 with lunch. She got up from where she was assisting Resident #7 and Resident #63 and walked over to Resident #105. CNA #5 tried to arouse Resident #105 by</p>	F 0371	<p>1) 1. No harm for resident's #1 , 7, 63, and 105, was observed after the interactions by C.N.A #5 and through further follow-up. 2. All residents have the potential to be affected by this action. 3. Nursing staff to be in-serviced on proper sanitation between interactions with multiple residents at the same time. In-servicing to be completed by SDC or designee by 7/2/2016. 4. Nursing administration to audit staff for washing hands in between changing tasks daily for 30 days and then weekly for 30 days and then monthly for 90 days. Results will be presented to monthly PI committee. Pi Committee will determine further audits as needed. 2) 1. Staff knew of mistake and corrected after completed. 2. Potentially all resident on puree</p>	07/02/2016

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	<p>lightly shaking him, rubbing his arms and calling his name for several seconds. She went back to assisting Resident #7 and Resident #63 with their lunch and did not sanitize her hands between touching residents. CNA #3 assisted Resident #105 with his lunch, repositioned him, and rubbed his arm. She then assisted Resident #1 and Resident #71 with their lunch without using hand sanitizer or hand washing.</p> <p>During an interview on 6/01/2016 at 11:25 a.m., the Director of Nursing Services (DON) indicated staff should have washed their hands or use hand sanitizer between assisting residents.</p> <p>A current policy titled "In-service on Food Handling of Resident Food & Storage of Resident Food for Non-Foodservice Associates" received from the DON on 6/1/16 at 12:10 p.m., indicated, "...Remember you must wash your hands: a. when changing tasks...."</p> <p>2. During an observation of puree food preparation, on 5/26/2016 at 9:30 a.m., Cook #7 placed items in a sealed bag and placed the bag under a counter. He was observed touching the counter and the baggie. He retrieved a container from a counter and set up the puree machine. He did not wash his hands before using a</p>		<p>foods could be affected.</p> <p>3. All dietary staff in-serviced on proper sanitation in food preparation on 5/25/16 by Food Service Director.</p> <p>4. Dietician, Dietary Manager or Designee will perform Audits, at a minimum, of 3 times a week for 30 days and randomly thereafter for 60 days to ensure compliance. Audits will be brought to PI committee for review. PI committee will evaluate further action as audits determine.</p> <p>3) 1. Box of beef was properly sealed and stored, as was cake and fruit cocktail covered properly at time of survey 5/25/16.</p> <p>2. Potentially all residents could be affected.</p> <p>3. Staff in-serviced on 5/25/2016 by Food Service Director on proper storage of food products.</p> <p>4. Audits to be performed at a minimum of 3 times a week for 30 days and then randomly for 90 days by Dietician, Food Service Manager, or designee. Findings will be reported to PI committee for monthly review. PI Committee will determine other action as deemed from results.</p> <p>4)1. Temperature log on 300 Hall was replaced with a new log that reflect the monitoring of the refrigerator and freezer temperature. Items is all refrigerator on the units were removed and replaced on 6/1/16. Hand sanitizer provided to staff.</p> <p>2. Every refrigerator on all units were audited for correct temperature logs, thermometers</p>	

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	<p>spatula to place fish in the puree machine.</p> <p>During an interview on 5/26/16 at 9:44 a.m., Cook #7 indicated he should have washed his hands prior to food prep.</p> <p>During an interview on 5/26/2016 at 9:45 a.m., the Dietician indicated staff should have washed their hands prior to starting food preparation.</p> <p>A current policy titled "Hand Washing," received on 5/26/16 from the Dietary Manager indicated, "...Guidelines Staff washed hands at the minimum as necessary to remove contamination and after the following ...During food preparation....After engaging in other activities that contaminate the hands...."</p> <p>3. Food storage was observed on 5/25/16 at 10:28 a.m. to 11:31 a.m. with the Dietary Manager. A box of frozen beef patties and a vanilla sheet cake were stored uncovered in the freezer. A tray of fruit cocktail was uncovered in the refrigerator. The Dietary Manager indicated the box of beef patties should have been closed and the cake should have been covered.</p> <p>During an interview on 5/25/2016 at 11:31 a.m., the Dietary Manager</p>		<p>and dates and names and items in the refrigerators 6/1/16.</p> <p>3. The SDC or designee will in-service licensed nursing staff Residents Food Storage and Hand washing and sanitizing by 7/2/16</p> <p>4. Nursing administration to audit unit temperature log and staff hand washing. Temperature logs audits will be completed daily for 30-days, then weekly for 30-days then monthly. Five staff members will be audited daily for 30-days, then weekly for 30 days then monthly. Results will be presented to PI monthly. PI to determine the need for further audits.</p> <p>5) 1.Documentation for that day and forward has been completed by Dietary</p> <p>2. All refrigerators that dietary uses for storage can be affected.</p> <p>3. All dietary staff were in-serviced by Food Service Manager on proper documentation on 5/25/2016.</p> <p>4. The Dietician, Food Service Manager, or designee to perform audits, at a minimum , of 3 times per week and as needed for 30 days and then randomly for 90 days or until 100% compliant. Findings will be presented to PI Committee monthly. PI Committee will determine further action as needed through data presented.</p> <p>6) 1. Both 300 hall and 200 hall nourishment refrigerators and freezers have thermometers and logs are being kept. Logs are in place and being documented daily.</p>	

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	<p>indicated foods in the freezers and refrigerators should have been covered.</p> <p>A current policy titled "Sanitary Food Handling" received on 6/2/16 at 11:20 a.m., from the Dietary Manager indicated, "...Foods should be covered until ready to serve..."</p> <p>4. During an observation on 6/01/2016 at 10:51 a.m., in the 300 hall nourishment room refrigerator, fruit was observed in an undated container and a frozen ice cream dessert was stored in an unlabeled and undated restaurant bag.</p> <p>During an interview on 6/01/2016 at 11:02 a.m., the DON indicated food should have been dated and labeled when placed in the nourishment freezer/refrigerator.</p> <p>A current policy titled "Food Storage" received on 6/1/16 at 12:10 p.m., by the DON, indicated "...If item is not in its original container, it must be place in a secure container and labeled 'appropriate...6. Dating a. We must use the 'use by date' on all food placed in the refrigerators...."</p> <p>5. During an observation of the 300 hall set up kitchen on 5/25/2016 at 11:10 a.m., the temperature log for the</p>		<p>2. All nourishment room refrigerators and freezers are at risk.</p> <p>3. Night shift Nursing staff to be in-serviced on daily monitoring of freezers and refrigerators for thermometers and temperature monitoring by the SDC or designee.</p> <p>4. Audits will be performed no less than 3 times a week for 30 days for compliance and randomly for the following 90 days or until 100% compliance. Findings will be presented to PI Committee for review. PI Committee will determine further action as deemed necessary through reviews.</p>	

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	<p>refrigerator was observed without documentation.</p> <p>During an interview on 5/25/16 at 11:10 a.m., Dietary Aid #8 indicated she forgot to complete the temperature logs for the refrigerator.</p> <p>A review of the temperature log for the 300 hall set up kitchen, on 5/25/16 at 11:28 p.m., indicated May 1st and May 2nd were the only dates with temperatures logged for the month of May 2016.</p> <p>6. During an observation on 6/01/2016 at 10:51 a.m., no thermometer was observed in the freezer in the 300 hall nourishment room refrigerator.</p> <p>On 6/01/2016 at 10:59 a.m., a review of the 300 hall nourishment refrigerator temperature log for May indicated freezer temperatures were not monitored. The log had a place to document refrigeration temperatures but no place to document freezer temperature.</p> <p>The 200 hall nourishment refrigerator logs were reviewed on 6/01/2016 at 11:13 a.m. and did not indicated refrigerator temperatures were monitored May 22-31, 2016 and freezer temperatures were not monitored May</p>			

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F 0514 SS=D Bldg. 00	<p>3,5,7,11,12,14,17,23,28,29,30, 2016.</p> <p>During an interview on 5/25/2016 at 11:31 a.m., the Dietary Manager indicated refrigeration temperatures should have been monitored twice daily.</p> <p>During an interview on 6/1/2016 at 11:13 a.m., the DON indicated refrigerator and freezer temperatures should be monitored and recorded daily. She further indicated a thermometer should have been kept in all the refrigerator's and the freezer's to ensure food's are kept at safe temperatures.</p> <p>A current policy titled "Cold Food Storage" received from the DON indicated, "...Temperatures should have been recorded at least twice daily on a posted log...."</p> <p>This federal tag relates to Complaint IN00199941.</p> <p>3.1-21(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE</p>				

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	<p>SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurate after a change in condition was noted for 1 of 4 residents reviewed for complete and accurate skin treatment records (Resident #75).</p> <p>Finding includes:</p> <p>The record for Resident #75 was reviewed on 5/31/16 at 3:20 p.m. Diagnoses included, but were not limited to, joint disorder right ankle and foot, and pressure ulcer sacral region.</p> <p>A care plan, dated 5/27/14, indicated the resident was at risk for developing a pressure ulcer. Interventions included, but were not limited to, complete weekly skin assessments.</p>	F 0514	<p>1.Skinassessment was completed on Resident 75# on 5/23/16 and the sheet was placed in residents #75 chart.</p> <p>2.Residentswho receives weekly skin assessments have the potential to be effected,therefore those residents will have a 100% audit for the Weekly Skin Assessmentsheet. Audits to be completed by 7/2/16.</p> <p>3.The SDCor designee will in-service licensed nursing staff on Medical Records Keepingand Skin Assessments. In-serving to becompleted by 7/2/16.</p> <p>4.Nursingadministration to audit Weekly Skin Assessment Sheets. Audits will be completeddaily for 30-days, then weekly for 90-days, then monthly. Results will bepresented to PI monthly. PI to determine the need for further audits.</p>	07/02/2016

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	<p>The May, 2016, TAR (Treatment Administration Record) indicated a treatment, ordered 1/26/16, was for skin prep (protective barrier wipes) to right plantar (sole of the foot) daily for protection.</p> <p>The Director of Nursing (DON) provided a copy of the TAR on 6/1/16 at 8:50 a.m. The TAR did not indicate this treatment was applied on May 17, 18, 20, and 21, 2016, as indicated by a circle surrounding LPN #2 ' s initials on those dates.</p> <p>On 6/1/16 at 3:05 p.m., the DON provided another copy of the same TAR for May, 2016. The DON indicated the TAR she just provided was copied on 5/23/16 and did not indicate any treatments had been missed in May 2016. No circles were present around any initials to indicate treatments were not applied. She indicated she did not realize her copy was different than the copy previously provided until she had reviewed the TAR.</p> <p>During an interview with LPN #2 on 6/1/16 at 11:05 a.m., she indicated she had not done the skin prep treatment for several days during the period May 12, 2016 through May 23, 2016 because there was no skin prep available.</p>			

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F 9999 Bldg. 00	<p>During an interview on 6/1/16 at 11:40 a.m. the DON indicated she was unable to provide weekly skin assessment sheets for Resident #75 because they were missing from the resident's medical record.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p> <p>3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (5) Needs of specialized populations served.</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a</p>	F 9999	<p>1.LPN #30is no longer an employee of Westside Village. RN #32 has been removed from the schedule at Westside Village.</p> <p>2.A 100%audit to be completed on employee files to assess for PPD administration compliance and Dementia, Residents' Right and Abuse training. Audits will becompleted by 7/2/16.</p> <p>3.TheSDC/designee will in-service staff on Dementia, Residents' Rights, and Abuse. Current employees out of compliance will beadministered the PPD by 7/2/16. In-serving to be completed by 7/2/16.</p> <p>4.Administration/designeeto audit employee records for completion of in-service training. Audits will becompleted twice monthly for 90-days. Results will be presented to PI monthly.PI to determine the need for further audits.</p>	07/02/2016

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	<p>previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or</p>			

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	<p>preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 1 of 10 employees had second step tuberculosis(TB) screening upon hire [Licensed Practical Nurse (LPN #30)] and failed to ensure 2 of 10 employees [Registered Nurse (RN #32)] and [Dietary Aide (DA #31)] received annual dementia in-service training and failed to ensure RN #32 received annual abuse and residents rights in-service training. This deficiency had the potential to effect 97 of 97 residents.</p> <p>Findings include:</p> <p>1. Employee records were reviewed on 6/2/16 at 11:34 a.m. for evidence of TB screening upon hire or annually for employees who worked in the facility.</p> <p>State form 5440, "Employee Records," provided on 5/26/16 at 3:00 p.m. by Business Office Manager (BOM) #33, indicated Licensed Practical Nurse (LPN) #30 began employment on 4/19/16 and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
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	<p>did not have the second TB.</p> <p>During an interview on 6/2/16 at 11:35 a.m., the Assistant Director of Nursing (ADON) indicated she was unable to locate documentation of second step tuberculosis screening test for LPN #30.</p> <p>On 6/2/16 at 12:08 p.m., the Director of Nursing (DON) provided the current policy titled, "Life Care Centers of America, Inc Tuberculosis Control and Purified Protein Derivative (PPD) Testing." The policy stated, "....Pre-employment examination of all employees must include screening for TB..."</p> <p>2. Employee records were reviewed on 6/2/16 at 11:40 a.m. for in-service training. State form 5440, "Employee Records", indicated Registered Nurse (RN) #32 began employment 11/23/02 and did not have annual dementia training, abuse, and resident rights.</p> <p>State form 5440, "Employee Records" indicated Die tray Aide (DA) #31 began employment 10/2/14 and did not have annual dementia training.</p> <p>During an interview on 6/2/16 at 11:45 a.m., Assistant Director of Nursing (ADON) indicated she was unable to</p>			

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	<p>locate documentation to indicate DA #31 and RN #32 received annual dementia training. The ADON indicated she was unable to locate documentation RN #32 received residents' rights and abuse training.</p> <p>During an interview on 6/2/16 at 4:00 p.m., the Executive Director (ED) indicated the facility policy was to follow the state rule for in-servicing staff.</p> <p>On 6/2/16 at 4:00 p.m., the ED provided the current policy titled, "Life Care Centers of America, Inc. Inservice Education." The policy stated, "...Inservice education will be provided to all employees according to State and Federal requirement based on the development needs of direct care staff...."</p>			