STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155685		02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVE ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00190501. Complaint #IN00190501- Substantiated. Federal/State deficiencies related to the allegations are cited at F371 and F456. Survey dates: January 25, 26, 27, 28, and 29 and February 1, and 2, 2016 Facility number: 000039 Provider number: 155685 AIM number: 100275130 Census bed type: SNF/NF: 147 Total: 147 Census payor type: Medicare: 08 Medicaid: 122 Other: 17 Total: 147 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please accept this Plan of Correction as our facility's response to alleged allegations that were cited during our Recertification Licensure Survey Our date of correction is March 3, 2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality Review completed by 14454 on February 10, 2016.			
F 0156 SS=B Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and			

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	periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the			

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	name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interviews, the facility failed to ensure 3 of 3 residents reviewed for liability notices were notified timely of the change in payor source. (Residents #25, 37 and 51) Findings include: 1. The Notice of Medicare Non-Coverage form for Resident #25 indicated the resident's last day of coverage was 10/20/15. The notice was not provided to the resident's representative until 10/21/15 at 1:35 P.M., one day after Resident #25's coverage ended. 2. The Notice of Medicare Non-Coverage form for Resident #37 indicated the resident's last day of coverage was 09/17/15. The form, which was not signed by Resident #37 or by her representative had "Verbally notified 11:30 09/15/15." There was no documentation who was verbally notified and no reason given as to why the form	F 0156	It is the facility practice to provide residents with liability notices timely of the change in payer source in accordance of Medicare guidelines Corrective action for alleged deficient practice: Social service staff are responsible for generating the notices and notification to the resident and/or POA Social Service staff were re-educated regarding the policy Res 25, 37, and 51 were reviewed and did not require any further notification for current status How others were identified to have potential to be affected by alleged deficient practice: The facility reviewed residents with a payer change within the last 30 days and found that notifications of payer changes were issued within Medicare guidelines (minimum of 2 days) Systematic change to ensure alleged deficient practice does not recur: The RNAC Director will notify the social service department of any anticipated changes during our daily stand-up meetings Social service department will issue the Medicare/Non-Covered notice the	03/03/2016

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	was not then signed by the appropriate person. 3. The Notice of Medicare Non-Coverage form for Resident #51 indicated her last day of covered services ended on 09/10/15. The form was documented as having been presented to her representative until 09/09/15 at 3:00 P.M. The form was signed by her representative on 09/09/15, less than 24 hours prior to the end of her coverage. Review of the facility's policy and procedure, titled Flowchart for Denial Letters- January 2015, and interview with the Administrator was conducted on 01/28/16 at 9:45 A.M. The policy indicated the notice of coverage changes for Medicare should be issued a minimum of 2 days prior to the last covered day. The Administrator indicated the therapy coordinator was supposed to notify the Social Service department of the need to issue the coverage letter. She indicated the incorrect timing of the notices for Resident's #25, #37 and #51 probably occurred because of some staffing issues and changes within the Social Services department. 3.1-4(f)(3)		same day they are informed. A copy of the notice (with resident/POA signature) will then be given to the RNAC director and BOM who will be responsible to compare the cut date with the notification date to ensure that the minimum 2 day notice has been met. A copy of the notice will be placed in the resident's financial file. How Corrective action will be monitored to ensure that alleged deficient practice does not recur: RNAC will keep a log that will include resident's name, last day of coverage and date that non-coverage letter is issued The log will be turned into the BOM each week and will be added to the ED/BOM meeting as part of their review. Results from this review will be documented in the ED/BOM meeting notes Any noted issues will be addressed/fixed at that time. This process will be 1x wk for 90 days. Facility QAPI team will review the wkly results 1 x month during QAPI meetings for 3 months for recommendations to continue or discontinue additional monitoring to maintain compliance with this requirement. 100% compliance with timely notifications of all non-covered letters within the 3 month time line will be the base line to recommend discontinuation of the monitoring as it is described in this POC.	

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F 0223 SS=D Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to prevent verbal abuse of a resident for 1 of 2 allegations of abuse reviewed. This affected 1 resident. (Resident #71) Finding includes: During an interview on 01/27/2016 at 1:18 P.M., Resident #82 indicated she was up at approximately 5:30 A.M. about a week and 1/2 ago and saw a CNA (Certified Nursing Assistant) walk up to Resident #71 and yell and scold her stating "Sit up, aren't you ashamed of yourself." During an interview on 01/28/2016 at 10:14 A.M., the Administrator and Director of Nursing indicated they were not aware of this event.	F 0223	It is the practice of this facility to have policies and procedures in place to prevent abuse toward residents The facility does have abuse protocols in place that include Indiana Health Department guidelines and routinely review the policy with our employees The facility has a zero tolerance for any type of actions that result in abuse allegations Corrective Action for residents found to be affected by alleged deficient practice: On 1-28-16, the ED and DON was notified of a alleged incident of possible verbal abuse Immediately, our abuse protocols were initiated, which includes ensuring the resident is safe and then proceed with the investigation After speaking with res #82, the DON was able to identify the specific CNA involved and found that the person had already been terminated for other work performance issues earlier	03/03/2016

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	During an interview on 01/29/2016 at 11:47 A.M., the Director of Nursing indicated the abuse allegation was substantiated and the identified CNA had been terminated due to another incident and had not worked at the facility for two weeks. On 2/1/2016 at 12:09 P.M., a copy of the incident report was received. The report indicated the investigation was complete. The investigation indicated the abuse allegation was substantiated. The description on the report indicated "...She said that approx. [approximately] 2 to 3 weeks ago she was going to dialysis at approx. 5:30 am and saw/heard a CNA who was tall and had a scarf on her head talking to (Resident #71). She said that she stated loudly "Sit up [Resident #71]. Sit up. That is a disgrace when you lean over like that. You should sit up."...." On 2/2/2016 at 2:27 P.M., the Director of Nursing provided the current Abuse Policy, dated 1/15/2015. The policy indicated "...Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability...."		in the month It was also confirmed that the CNA did not work in the facility for approx. 2 wks. A complete assessment was done for resident 71. There was no negative outcomes identified for this resident due to this incident. The facility reported the incident to ISDH as required. How others were identified to have potential to be affected by alleged deficient practice: Resident Interviews were conducted by staff throughout building There were no further reports of allegations at that time Systematic change to ensure alleged deficient practice does not recur: Staff in-serviced regarding facility policy and procedures Any new hires will receive Abuse training in orientation. Once a month the Education director in coordination with the SSD, will provide abuse policy review, which employees will be required to attend. Each current resident has been given a caring partner(member of management team) who will be responsible to report back to ED/DON any allegations that are made. Caring partner rounds will be discussed in stand-up meeting (mon-fri). Wkend Managers will be responsible to make rounds, talk with residents in general and to handle any issues that come up. How Corrective action will be monitored to ensure alleged deficient practice does not recur: The Unit managers will visit 5	

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	3.1-27(b)		residents daily (Mon-Friday) Concerns will be documented on grievance forms and turned into the ED for review and distribution to specific departments for solution. On wkends, the MOD will visit 2 residents from each hall and then follow the same process. SSD will maintain a log of grievances and will bring to dly stand-up meeting to review with the team. The grievance log will be reviewed by the ED/DON 1x wk for 90 days, the 2x month for 90 days The SSD will report results of the visits to the QAPI team 1x month for 3 months, who will be responsible to identify trends and recommend additional educational needs as appropriate. 3 months of no allegations will constitute threshold of 100% compliance and will be reviewed by the QAPI team to determine decrease and/or discontinuation of monitoring as it is identified in the POC.	
F 0241 SS=D Bldg. 00	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, record review and interviews, the facility failed to maintain dignity related to privacy during personal care and dressing a resident in clothing other than a hospital gown daily for 2 of	F 0241	It is the policy of this facility to promote a environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality as defined by federal	03/03/2016

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	3 residents reviewed for dignity. (Resident #9 and Resident #206). Findings include: 1. On 1/26/2016 at 10:15 A.M., Resident #206 was observed resting in her bed dressed in a hospital gown. At 2:07 P.M., Resident #206 remains resting in bed and continues to be dressed in a hospital gown. On 1/28/2016 at 9:54 A.M., Resident #206 was observed resting in bed she was awake and alert and was dressed in a hospital gown. On 2/1/2016 at 9:40 A.M., Resident #206 was observed resting in her bed dressed in a hospital gown. The clinical record for Resident #206 was reviewed on 1/28/2016 at 9:55 A.M. Resident #206 was admitted to the facility, on 12/25/2015, with diagnoses, including but not limited to: malaise, acidosis, hemolytic anemia, adult failure to thrive and lupus. The admission MDS (Minimum Data Set) assessment, completed on 1/1/2016, indicated the resident scored a 4 out of 15 on the BIMS (Brief Interview for Mental Status), severely cognitively impaired.		& State guidelines It is also the policy of this facility to honor resident choices as appropriate All CNA's working in our facility are certified staff and have received training on dignity and respect, at time of hire and periodically throughout their employment This includes dignity and respect during ADL care This is demonstrated annually during skills check off and also provided periodically throughout the year on a as needed basis Corrective action for alleged deficient practice: Res 206 was on hospice services and was actively dying Due to the fact that she was not getting up, the care plan team felt that it was appropriate to leave resident in a gown after personal care The residt and family were agreeable The family was not asked to bring in additional clothing as the resident was not getting up due to her condition and the team felt that additional clothing at this point was not necessary Res 9 was interviewed and it determined there were no ill effects related to alleged deficient practice CNA 7 received 1:1 training regarding correct protocol to protect resident's dignity How others were identified to have potential to be affected by alleged deficient practice: SSD conducted dignity interviews with 10 residents per hall , No noted trends were identified Staff will receive dignity and respect	

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	The resident required extensive 1 person physical assistance for dressing. The resident's assessment of preferences and activities indicated it was somewhat important for the resident to choose what clothes to wear. During an interview, on 1/28/2016 at 10:32 A.M., CNA (Certified Nursing Assistant) # 6 indicated the resident does not have very many clothing items to wear and since the resident does not get up out of bed the staff just dress her in a hospital gown every day. 2. On 1/26/16 at 11:20 A.M., CNA #7 and an unidentified CNA entered the room of Resident #9. CNA #7 indicated he was going to get the resident up out of bed with the use of a hoyer lift (a mechanical transfer device). CNA #7 and the unidentified CNA removed the covers from Resident #9 and placed the lift sling under the resident. Resident #9's roommate was seated in her recliner across the room. Neither CNA #7 or the unidentified CNA pulled the privacy curtain. Neither CNA #7 or the unidentified CNA was observed to speak to the resident or explain what they were going to do. During an interview on 2/2/2016 at 10:18 A.M., CNA #7 indicated when he enters		training on 2-29-16 Residents were also asked about choices regarding getting up or staying in bed The list of residents that were identified wishing to wear gowns during the day time and while in bed were confirmed and care plans updated to show their preference. The unit managers also did observation rounds. Systematic change to ensure alleged deficient practice does not recur: Resident preferences will be discussed during quarterly care plan meetings as part of the social services/activity sections to ensure the plan of care is current regarding their choices. Unit managers will conduct rounds in the morning prior to lunch to make sure residents are up and dressed. Staff Educator will shadow CNAs 2 times a week to provide hands on training as needed. How corrective action will be monitored to ensure deficient practice does not recur: Education Director will complete audit form on each CNA that is shadowed and will turn in results to the ADON for her review In-service training will be scheduled based upon the results of the audits and the employee needs. ADON will meet with DON 1 time per wk for 90 days and review staffing education needs based upon results of the shadowing audits. The DON will review any trends noted with QAPI team 1x month for 3	

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	a resident room to provide resident care he would first pull the privacy curtain and then he would explain to the resident and the roommate that he was going to provide care. 3.1-3(t)		months. Discontinuation of additional monitoring will be determined by 3 months of 100% compliance with CNA demonstration of proper technique during job shadows.	
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for choices received a shower according to their preference. (Resident #146) Finding includes: A clinical record review was conducted on 01/28/2016 at 9:49 A.M. The clinical record indicated Resident #146 was admitted on 6/15/2014. Her diagnoses	F 0242	It is thepractice of this facility to allow residents to make choices about aspects oftheir life in the facility that are significant to the resident in coordinationto federal and state guidelines. CorrectiveAction for alleged deficient practice: SSD spoke tores 6 and established a shower schedule per her preference. Res 6's C.P. was updated to include herpreference for showers. Care staff havebeen educated to res' shower preference.	03/03/2016

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	included but were not limited to: edema, acute embolism and thrombosis of deep veins of lower extremity, essential primary hypertension, other fatigue, other abnormalities of gait and mobility, personal history of other venous thrombosis and embolism, history of falling and pathological fracture other site sequela. The quarterly MDS (Minimum Data Set) assessment, dated 12/9/15, indicated the resident scored 14 of 15 on the BIMS (Brief Interview for Mental Status), cognitively intact. During an interview on 01/26/2016 at 10:14 A.M., Resident #146 indicated she doesn't get a shower on the day she is supposed to take it. On 01/28/2016 at 3:33 P.M., the Administrator provided the Bathing Type Detail Report. The form indicated Resident #146 did not receive a shower on her scheduled shower days: 12/30/2016, 01/02/2016, 01/06/2016, 01/16/2011 and 01/20/2016. A form received from Unit Manager #11 on 1/29/2016 at 11:31 A.M., indicated Resident #146 was to receive a shower on Wednesdays and Saturdays.		How otherresidents were identified to have potential to be affected by alleged deficientpractice: SSdepartment met with all residents regarding their shower preferences. Nursing then developed a new shower schedulefor care staff to follow based on the 100% audit results. Measuresput into place to ensure that alleged deficient practice does not recur: Showerpreferences will be reviewed with the resident and/or POA during quarterly careplan meetings to ensure that shower preferences have not changed since beingadded to the care plan. For newadmissions, shower preferences will be discussed at the time of admission bythe admitting nurse and will be communicated to the rest of the team members. How thecorrective action will be monitored to ensure alleged deficient practice doesnot recur: The Nursingunit manager will pull the detail shower report from care tracker 2 x's wk. Themanager will then speak to 5 residents that have had showers and confirm thatshowers were given per their choice. Results will be recorded on audit form and turned into DON/ADON forfurther auditing purposes. The ADON willpick 5 residents at random for each unit and will confirm with the	

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	During an interview on 01/29/2016 at 2:08 P.M., Resident #146 indicated she did not receive a shower on 1/23/2016 even though this was her shower day. During an interview on 1/29/2016 at 2:55 P.M., CNA (Certified Nursing Assistant) #12 indicated Resident #146 does not usually refuse showers. She further indicated Resident #146 is very alert and "doesn't usually forget." During an interview on 1/29/2016 at 3:00 P.M., Unit Manager #20 indicated she spoke with Resident #146 and Resident #146 indicated to her that she was unable to recall her shower on 1/20/2016. On 2/1/2016 at 11:23 A.M., the Director of Nursing provided a policy titled, "Bath, Shower," dated 1/4/2016, and indicated this was the current policy used by the facility. The policy indicated "...ASSESSMENT GUIDELINES: May include, but are not limited to: Condition of skin. Range of motion limitation. ADL (activities of daily living) function. Resident's preference for time of day, frequency and type of bath." 3.1-3(u)(1)		residentthat they received their showers as preferred. The DON will report to the QAPIteam 1x per month for 90 days and then 1x per quarter the results of the auditsshowing trends. Any identified compliance issues will be corrected. The QAPI team can recommend additionalauditing to be discontinued once the facility has reached and maintained 100%compliance with following shower preferences.	

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	155685		02/02/2016

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F 0250 SS=E Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interviews the facility failed to ensure medically related social services regarding behavior management was developed for 1 of 5 residents reviewed for unnecessary medications. (Resident #90) In addition, the facility failed to ensure routine dental services, covered by Medicaid were offered to Resident #123. This potentially affected 84 of 123 residents who receive Medicaid monies. Findings includes: 1. The clinical record for Resident #123 was reviewed on 01/28/2016 at 2:05 P.M. Resident #123 was admitted to the facility on 02/13/15 with diagnoses, including but not limited to: fracture of the left femur, diabetes mellitus, encephalopathy, polyosteoarthritis, chronic obstructive pulmonary disease, generalized anxiety, history of falling, pain, and acute embolism and thrombosis of the deep veins.	F 0250	It is the policy of this facility to provide medically related social services to attain or maintain the practicable, physical, mental and psychosocial well-being of each resident Corrective Action for alleged deficient practice: Resident 90 was assessed by social services and a behavior plan was developed and implemented to address resident's current diagnosis CP was also updated to include diagnosis of Bi-polar and Personality disorder Resident 123 was referred to facility dental provider and is scheduled to see them on 3-2-16 However, facility received confirmation from the dental provider that resident 123 was offered dental services on 4/17/15 and declined services How other residents were identified with potential to be affected by alleged deficient practice: SS department has completed 100% audit of current in-house residents that would like to or need to see the dentist and have made referrals tour dental provider SS department also completed 100% audit review of	03/03/2016

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	On 01/26/2016 at 01:59 P.M., Resident #123 was observed sleeping in her wheelchair in the cafe lounge. Her upper dentures were noted to have fallen completely out of her mouth and were laying on her chest. On 1/28/2016 at 3:12 P.M., Resident #123 was observed in her wheelchair in the cafe lounge watching television. She was noted to have upper dentures but no lower dentures. She indicated her lower dentures were "at home" in a drawer. She indicated they did not fit and she hoped the facility was getting her new ones. The admission MDS (Minimum Data Set) assessment, completed on 02/24/15, indicated the resident did not have natural teeth but did not have any ill fitting or missing dentures. The most recent quarterly MDS assessment, completed on 12/15/15, indicated she had no ill fitting or missing dentures. During an interview on 01/29/16 at 9:56 A.M., the Social Service Director (SSD), Employee #82 indicated Resident #123 was not seen by an in house dental services and there was no outside dental exam in her chart since she was admitted to the facility in February 2015. Employee #32 indicated she had not		residents receiving antipsychotic and anti-depressant medications to ensure there is a current diagnosis and care plan Systematic change to ensure alleged deficient practice does not recur: Dental services information has been added to the admission packet It will be the admission director's responsibility to review with the resident/family and have the acknowledgement signed A copy of the acknowledgement will be kept in the financial folder and on the medical record Staff will use a social service referral form to communicate to the social services director who will then be responsible to arrange for the service Each resident's diagnosis and medication list will be reviewed by the behavior committee on the initial admission date and then quarterly thereafter to ensure that current medications have appropriate diagnosis and that there are current behavior plans in place How Corrective action will be monitored to ensure that alleged deficient practice does not recur: The unit manager will be responsible to complete chart audits for new and readmits within 24 hours of the admission Audit results will be given to the nurses for correction and follow-up The DON/ADON will complete 1 audit per hall per wk to ensure compliance with diagnosis and care plans During	

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	contacted the family regarding any denture issues or the need for routine dental care. During an interview, on 01/29/16 at 9:58 A.M., the Unit Manager, LPN (Licensed Practical Nurse) #4 indicated when the resident was admitted she only had upper dentures and she had not notified family regarding any denture issues as the resident had not complained of any issues. Further interview with SSD , Employee #32, on 01/29/16 at 10:00 A.M. indicated routine dental services were set up on admission if the resident or family requested the service but the in house dental services were not offered to Medicare or Medicaid residents as part of the Admission process. There was no documentation of any refusal of in house dental services or any documentation of offering the services. Employee #32 indicated most residents and families elected not to select in house dental services because of the "liability" charge. Employee #32 indicated there was a charge, which came out of the resident's liability, to pay for the dental services. Further discussion indicated the charge did not impact the personal monies of the Medicare or Medicaid residents, but rather the amount the facility received		the wkly BOM/ED meeting, we will audit financial files for any new admissions to ensure that the dental service was offered at admission time and that it was passed on the social service director The ED will review audit results 1 x wkly for 90 days All results will be shared with the QAPI team members 1 x month until 100% threshold has been reached and maintained for 90 days	

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	from either Medicare or Medicaid. It was unclear if the covered services were presented to resident's and/or their families in a manner which was clear as to the manner in which the service was provided and billed. There was no documentation of refusal of in house dental services and no documentation social services or nursing had made Resident #123's family aware of any dental needs. Employee #32, who had been present during the previous observation of Resident #123 when her upper dentures had fallen completely out of her mouth, indicated she was not aware of any issues. Information provided by the Administrator, on 02/01/16 at 9:40 A.M., indicated of the facility's 123 residents who received Medicaid monies, only 39 were "set up" for the in house dental services. The Admission folder, given to residents and families on admission to the facility was reviewed on 02/01/16 at 10:00 A.M. The folder referred to an itemized list of covered services for Medicaid and/or Medicare but there was no itemized list informing the family and/or resident of covered dental services.			

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	During an interview, on 02/01/16 at 10:15 A.M., SSD #32 indicated the Business Office took care of the "billing" and forms for new admissions. She indicated again she did not routinely offer in house dental services to Medicaid residents but would "set them up" with in house dental if they requested the service. During an interview, on 02/01/16 at 10:30 A.M., the Business Office Manager, Employee #37 indicated she only had the resident and/or family sign the appropriate form electing the facility's in house dental services if she was notified by Social Services of the need. She indicated she did not routinely offer Medicaid residents covered in house dental services. She indicated she did not know of any "bill" sent to residents and/or their families after they elected in house dental services. She did indicated they should receive an approval letter from Medicaid. 2. The clinical record review was conducted on 01/28/2016 at 9:56 A.M., and indicated Resident #90 was admitted on 11/14/2014. Diagnoses included but were not limited to: Bipolar disorder, bipolar disorder current episode mixed moderate and personality disorder. There were no careplans related to			

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	diagnoses of Bipolar and Personality disorder. There were also no care plans related to behaviors. During an interview, on 02/1/2016 at 10:00 A.M., Unit Manager #11 indicated Resident #90 did not have a care plan for his diagnoses of Bipolar and Personality disorders. During an interview on 02/02/2016 at 10:00 A.M., Social Service employee #12 indicated Resident #90 did not have any behavior care plans or documentation related to his diagnoses of Bipolar and Personality disorder. On 2/2/2016 at 10:57 A.M., the Director of Nursing provided a policy titled "Interdisciplinary Care Plan," dated 2/26/2015, and indicated the policy was the one currently used by the facility. The policy indicated "...The social services staff will communicate mental and psychosocial problems, needs, and concerns to the interdisciplinary team for inclusion in the care plan. They will include: --- Historical issues currently managed with interventions (drug and non-drug) that place the resident at risk for decline in functioning...." 3.1-34(a)			

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F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on observation, record review and	F 0272	It is the practice of this facility to	03/03/2016

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	interviews, the facility failed to ensure the annual MDS (Minimum Data Set) assessment was accurate regarding oral and dental health for 1 of 3 residents reviewed for dental needs. (Resident #123) Finding includes: The clinical record for Resident #123 was reviewed on 01/28/2016 at 2:05 P.M. Resident #123 was admitted to the facility, on 02/13/15, with diagnoses, including but not limited to: fracture of the left femur, diabetes mellitus, hypernatremia and hyperosmolality, encephalopathy, polyosteoarthritis, chronic obstructive pulmonary disease, generalized anxiety, history of falling, pain and acute embolism and thrombosis of the deep veins. On 01/26/2016 at 01:59 P.M., Resident #123 was observed sleeping in her wheelchair in the cafe lounge. Her upper dentures were noted to have fallen completely out of her mouth and were laying on her chest. On 01/28/2016 at 3:12 P.M., Resident #123 was observed in her wheelchair in the cafe lounge watching television. She was noted to have upper dentures but no lower dentures. She indicated her lower		ensure MDS assessments are accurate to the resident's current condition Corrective action for alleged deficient practice: The annual MDS for resident 123 was corrected to show current oral and dental health needs Her family was contacted and permission was given for resident to be seen by the dentist to see if she can get lower dentures The family acknowledged that the resident's lower denture was at home and said they would bring in How other residents were identified to be affected by alleged deficient practice: The RNAC Coordinator and Unit Manager have identified residents with dentures and have compared the list to the most current MDS to ensure accuracy for oral needs Systematic changes to ensure alleged deficient practice does not recur: The MDS Coordinator and the MDS Assistant will complete 3 resident peer to peer audits each per wk. Each person will review the other's entered information to ensure accuracy. Any discrepancies will be discussed with the Director of Nursing and corrected MDS assessments will be generated as appropriate. How corrective action will be monitored to ensure deficient practice does not recur: Peer to peer audit outcomes will be given to the DON who will review for trends This information will be shared with	

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	dentures were "at home" in a drawer. She indicated they did not fit and she hoped the facility was getting her new ones. The admission MDS assessment, completed on 02/24/15, indicated the resident did not have natural teeth but did not have any ill fitting or missing dentures. The most recent quarterly MDS assessment, completed on 12/15/15, indicated she had no ill fitting or missing dentures. On 01/29/16 at 9:56 A.M., the Nursing Unit Manager, LPN (Licensed Practical Nurse) #4 was interviewed. She indicated the MDS assessments were inaccurate regarding the denture issues for Resident #123. She indicated on Resident #123's personal inventory and there was only upper dentures indicated on the form, which was completed on admission to the facility. 3.1-31(c)(9)		QPAI team 1xmonth for 6 months or until threshold of 100% is obtained. Compliance will be considered to be met and additional monitoring will be discontinued when audits show 3 months of accuracy.	
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the			

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	assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on record reviews and interviews, the facility failed to develop a comprehensive care plan with interventions to address the use of an antipsychotic, antianxiety, thyroid, cholesterol and diuretic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident #152 and #79) Findings include: 1. The clinical record for Resident #79 was reviewed on 01/28/2016 at 1:18 P.M. Resident #79 was admitted to the facility, on 09/11/14, with diagnoses, including but not limited to: dementia without behavioral disturbance, hypothyroidism, history of urinary tract	F 0279	**Corrective Actiontaken for residents found to be affected by alleged deficient practice:** - Res #79 was assessed and a care plan was developed to include currentdiagnosis and medications. - Res #152 was assessed and a care plan was developed to include currentdiagnosis and medications.. - - **Identification ofother residents with potential to be affected by alleged deficient practice:** - 100% care plan review completedfor residents who are currently receiving antipsychotic, antianxiety, thyroid,cholesterol and diuretic medications and care plans were	03/03/2016

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	infections, peripheral vertigo, hypertension, and major depressive disorder single episode, generalized anxiety and hyperlipidemia. The current physician's orders for medications include the following: Simvastatin (a medication to treat high cholesterol) 20 mg (milligrams) at bedtime and Levothyroxine Sodium (a medication to treat low thyroid stimulating hormone levels) 75 mcg (micromilligrams) one tablet once a day There were no care plans to address any aspect of the resident's diagnoses and treatment for hyperlipidemia (elevated cholesterol levels) or hypothyroidism. The most recent MDS (Minimum Data Set) assessment, completed on 12/03/15, indicated hypothyroidism and hyperlipidemia were both marked as current diagnosis. During an interview, on 02/01/2016 at 2:13 P.M., with RN (Registered Nurse)#31, the MDS coordinator, she indicated the facility did not necessarily care plan those (hyperlipidemia and hypothyrodism) conditions. When RN #31 was informed of the lack of a monitoring laboratory study in regards to the hyperlipidemia medication the		developed to addressthese conditions. **Measures put intoplace to ensure alleged deficient practice does not recur:** Licensed nursing and socialservice staff will receive in-service training regarding facilityprotocols/policies regarding the care planning process of resident diagnosisand treatment plans.. Unit managers willcomplete admission audits within 48 hrs to ensure all diagnosis and medicationsare captured. The Diagnosis list andmedication list will be reviewed by the IDT team at the first care plan andcare plans will be developed accordingly. **How correctiveaction will be monitored to ensure alleged deficient practice does not recur:** Unit managers will audit diagnosis and medication list of 2 residents perweek to ensure that treatment plan is addressed. Audit results will be turned into the DON whowill review and discuss with QAPI team members 1x month x 6 months or until100% threshold is met. Additionalmonitoring will be discontinued on recommendation from QAPI team after audit scoresindicate 100% compliance for 3 months.	

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	resident received and the subtherapeutic laboratory level of the hypothyroidism medication without adequate follow up and no plan to address either potential issue, she still reiterated the facility did not necessarily care plan all diagnoses. 2. On 1/28/16 at 10:27 A.M., a review of the clinical record for Resident #152 was conducted. The record indicated the resident was admitted on 7/10/14. The resident's diagnoses included, but were not limited to:dementia with behavioral disturbance, type 2 diabetes mellitus, problems related to psychosocial circumstances, hypertension, anxiety disorder, edema, restlessness, agitation and psychotic disorder. A Quarterly Minimum Data Set (MDS) Assessment, dated 12/23/15, indicated the resident's Brief Interview Mental Status (BIMS) was 14 (normal cognition). The behavior section indicated the resident had no psychosis (hallucinations/delusions) and the medication section indicated the resident received an antipsychotic, antianxiety and a diuretic medication, 7 days a week. The Medication Administration Record (MAR) indicated the resident was being administered the following medications: Ativan 0.5 milligrams (mg) at bedtime		- - - - -	

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	for behavior disturbance (the Ativan was discontinued on 1/27/16), metformin 500 mg BID (twice a day) (a medication for diabetes), olanzapine (Zyprexa) 15 mg at bedtime for behavioral disturbances, lasix 40 mg daily for cardiovascular disease and potassium chloride 20 milliquivalents (mEq) a day (taken to prevent low potassium). An Order Summary Report, dated 1/6/16, indicated lorazepam (Ativan) 0.5 mg was ordered on 11/12/14 with a start date of 11/12/14. The olanzapine (Zyprexa) 15 mg was ordered on 7/10/14 and started on 7/10/14. A Careplan for potential drug complications, revised on 12/31/15, indicated the resident's use of an antipsychotic medication. The interventions included but were not limited to: monthly pharmacy review, observe for side effects of antipsychotic medication and reduction plan as recommended by physician/pharmacist. There was no careplan for the use of a diuretic medication. A Progress Note-General Note, dated 1/27/16, indicated "...Ativan d/c'd [discontinued] related to pharmacy recommended dose reduction...." Another General Note, dated 7/9/15,			

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	indicated "...MD orders to continue with Zyprexa 15 mg daily, rejected pharmacy suggestion to decrease dose to 10 mg daily, pharmacy notified." A Clinical Pharmacist Letter to Physician Services, dated 6/25/15, indicated the Pharmacist recommended a gradual dose reduction for Zyprexa 15 mg a day to 10 mg a day. The recommendation was rejected with no clinical rational documented on the form as requested. Another pharmacist recommendation, dated 1/25/16, indicated a dose reduction of the Ativan 0.5 mg daily to 0.25 mg daily. At the bottom of the phone was written "...per phone order - D/C [discontinue] Ativan 1-27-16...." Another pharmacist recommendation, dated 1/25/16, indicated a reduction of the Zyprexa 15 mg daily to Zyprexa 10 mg daily. The physician accepted the recommendation on 1/28/16. During an interview, on 1/28/16 at 3:11 P.M., the Social Service Director indicated there were no behaviors or interventions addressed on the careplan for Resident #152. She further indicated the physician reduced the Zyprexa dosage today. During an interview, on 1/29/16 at 9:50 A.M., the Social Service Director			

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	indicated she could not find any other GDR's (Gradual Dose Reductions) from the pharmacist for the Ativan or Zyprexa prior to July of 2015. During an interview, on 2/1/16 at 3:55 P.M., the MDS Coordinator indicated she does not do the careplans for behaviors and related interventions. The MDS Coordinator indicated the Social Service Director would initiate the behavior careplan with interventions. She further indicated when she had completed a MDS assessment for a resident on antipsychotic medications and noted the resident had no behaviors she would notify the Social Service Director to inquire about a possible reduction of the medication. On 2/2/16 at 9:20 A.M. the Director of Nursing provided a current policy titled " Interdisciplinary Care Plan," dated 2/24/15. The policy indicated "...Purpose: The interdisciplinary care plan is implemented to guide the Living Center in the provision of necessary care and services... Care Plan - The social services staff will communicate mental and psychosocial problems, needs, and concerns in the interdisciplinary team for inclusion in the care plan...Specific Approaches - The social services staff will contribute specific approaches			

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	[interventions] inclusive of social services methods and techniques to address problems, needs, and concerns identified by the interdisciplinary team...." 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to ensure the care plan was followed regarding dental exams for 1 of 3 residents reviewed for dental care. (Resident #123) The facility also failed to ensure the care plan regarding nail care was followed for 1 of 3 residents reviewed for ADL's (activities of daily living) (Resident #103) In addition, the facility failed to ensure the care plan was followed regarding dialysis fistula care for 1 of 2 residents reviewed who received dialysis. (Resident #82) Findings include:	F 0282	It is the practice of this facility to ensure care plans are followed for dental care, nail care & fistula care Corrective Action taken for alleged deficient practice: Res 123 has a referral for dental services and is scheduled to see the dentist on 3-2-16 Her family was contacted by social services and they stated they will be bringing in her lower denture even though the resident has not worn prior to coming into the facility Res 103's nails were cleaned Resident's nail care was added to her plan of care to be completed during her shower days Nursing will be responsible to make sure her nails are clean Nursing staff will be in serviced by 2-29-16	03/03/2016

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	1. On 01/26/2016 at 01:59 P.M., Resident #123 was observed sleeping in her wheelchair in the cafe lounge. Her dentures were noted to have fallen completely out of her mouth and were laying on her chest. On 01/28/2016 at 3:12 P.M., Resident #123 was observed in her wheelchair in the cafe lounge watching television. She was noted to have upper dentures in place, but no lower dentures. She indicated her lower dentures were "at home" in a drawer. She indicated they did not fit and she hoped the facility was getting her new ones. The clinical record for Resident #123 was reviewed on 01/28/2016 at 2:05 P.M. Resident #123 was admitted to the facility, on 02/13/15, with diagnoses, including but not limited to: fracture of the left femur, diabetes mellitus, encephalopathy, polyosteoarthritis, chronic obstructive pulmonary disease, generalized anxiety, history of falling, pain, and acute embolism and thrombosis of the deep veins. The admission MDS (Minimum Data Set) assessment, completed on 02/24/15, indicated the resident did not have natural teeth but did not have any ill fitting or		regarding proper nail care technique. Res #82's plan of care was reviewed and treatment record was changed to require nurse's initial each day to ensure that her fistula area is being checked including days she is not at dialysis Nursing Care staff have been educated on protocols and procedures for providing care to a dialysis resident. How other residents were identified to have potential to be affected by alleged deficient practice: 100% observation audit was conducted on residents by the unit managers Residents with nail concerns were identified and nail care provided. SSD completed 100% audit of residents with dental needs and has made referrals accordingly to those residents who approved for the services. Nursing Department reviewed other dialysis patients' currently in house to ensure that plan of care was being followed Systematic Changes to ensure alleged deficient practice does not recur: A tracking log has been implemented that will be kept by the SS department to follow resident dental needs and to make referrals accordingly. Social Services will be responsible to schedule the dentist on routine visits to our facility. All new residents will be informed about dental services at time of admission by the admissions director and will inform the SSD what their	

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	missing dentures. During an interview, on 01/29/2016 at 9:58 A.M., LPN (Licensed Practical Nurse) #4, indicated the MDS assessment was inaccurate. The most recent quarterly MDS, completed on 12/15/15, indicated she had not ill fitting or missing dentures. The health care plan regarding Activity of Daily Living (ADL's), current through 03/22/16, included the following intervention: "Oral care bid (twice a day) and PRN (as needed). Has upper dentures. Dental exams as necessary." During an interview, on 01/29/16 at 9:56 A.M., SSD (Social Service Director) #32 indicated Resident #123 was not seen by an in house dental services and there was no outside dental exam in her chart since she was admitted to the facility in February 2015. Employee #32 indicated she had not contacted the family regarding any denture issues or the need for routine dental care. During an interview on 01/29/16 at 9:58 P.M., Unit Manager, LPN #4 indicated when the resident was admitted she only had upper dentures and she had not notified family regarding any denture issues as the resident had not complained		preference is. Nursing will complete oral assessments during the admission assessment and will inform SS if they need to contact the family to bring in dentures. The nail care will be completed during shower days. Activities will hold a nail care saloon day 1 day/week for anyone who wants to have nails cleaned and/or painted. Dental services/oral care will be monitored dly through the guardian angel program. Resident needs will be communicated to the unit manager or social service dly. Dialysis orders and monitoring has been added on the daily treatment sheets and will require the nurse to confirm fistula checks are being completed on days when the resident is not going to dialysis center How System will be monitored to ensure alleged deficient practice does not recur: Unit Managers and Guardian Angels will make daily rounds (Mon-Fri) checking and observing resident nails Any residents found to need nail care will be reported to the charge nurse who will be responsible to ensure they are cleaned. Audit forms will be utilized to record findings and will be turned into the ED for review. CNAs will also sign off that nail care was performed during shower on the shower sheets that are turned back in to the managers. DON will do random observations 3	

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	of any issues. During an interview on 01/29/16 at 10:00 A.M., SSD #32 indicated routine dental services were set up on admission if the resident or family requested the service but the in house dental services were not offered to Medicare or Medicaid residents as part of the Admission process. There was no documentation of any refusal of in house dental services. Employee #32 indicated most residents and families elected not to select in house dental services because of the "liability" charge. Employee #32 indicated there was a charge, which came out of the resident's liability, to pay for the dental services. Further discussion indicated the charge did not impact the personal monies of the Medicare or Medicaid residents, but rather the amount the facility received from either Medicare or Medicaid. It was unclear if the covered service was presented to resident's and families in a manner which was clear as to the charge for the service. There was no documentation of refusal of in house dental services and no documentation social services or nursing had made Resident #123's family aware of any dental needs. Employee #32, who had been present during the previous observation of Resident #123 when her		times wk looking at nails for 4 weeks, the 1 time wk for 4 wks. All results will be shared with QAPI team members 1 time month for 6 months. Additional monitoring can be discontinued on recommendation of the QAPI team members when there are no issues identified for 2 months consistently. The Unit manager will review the treatment record of dialysis patients once a day (Mon-Friday) for 4 weeks, then once a week for 4 weeks, then once a month for 90 days to ensure fistula checks are being completed according to the physician orders The ADON/DON will review the audit results once a week for 4 weeks and then once a month for 90 days. Results of these audits will be discussed in QAPI meeting once a month for 90 days. Consideration of discontinuing increased monitoring will occur when facility reaches benchmark of 100% accuracy for 30 days.	

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	upper dentures had fallen completely out of her mouth, indicated she was not aware of any issues. 2. On 1/26/16 at 2:36 P.M., Resident #103 nail tips were sharp and jagged. The nail beds had a dark brown substance underneath the nail. On 1/29/16 at 2:14 P.M., Resident #103 nail tips were observed to be jagged and had a brown substance under the nail beds. On 1/29/16 at 1:55 P.M., a review of the clinical record for Resident #103 was conducted. The record indicated the resident was admitted on 2/6/12. The resident's diagnoses included, but were not limited to: vascular dementia, heart failure, atrial fibrillation and anxiety. An Annual Minimum Data Set (MDS) Assessment, dated 12/8/15, indicated the resident's Brief Interview Mental Status (BIMS) score was 2, severe cognitive impairment. The resident required extensive assist of one person for personal hygiene. A careplan, initiated on 12/10/15, for physical functioning deficit related to self care impairment indicated the resident required extensive assist with bed			

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	mobility, transfers and eating. The interventions included but were not limited to: encourage choices with care, and nail care as needed and weekly. During an interview, on 1/29/16 at 2:15 P.M., CNA (Certified Nursing Assistant) #5 indicated the resident messes her hair up after staff comb, and they have to beg her to go to the rest room and get her brief changed. She is very difficult to provide care, we just have to keep trying. A bathing schedule was obtained from the East Unit Manager. The schedule indicated the resident was bathed this month on the following dates: 1/5, 1/7, 1/12, 1/14, 1/18, 1/21, 1/26 and 1/28/16. During an interview, on 1/29/16 at 3:00 P.M., the Unit Manager for the East Unit indicated the resident would have had her nails trimmed and cleaned on her bathing days. The resident's nail's were observed with the East Unit Manager at this time. The resident's nails were dirty and uneven. On 2/1/16 at 3:38 P.M. the Director of Nursing indicated there was no policy regarding nail care. 3. A clinical record review was conducted on 01/28/2016 at 9:53 A.M.,			

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	and indicated Resident #82 was admitted on 2/6/2015. Her diagnoses included, but were not limited to: end stage renal disease. During an interview on 02/02/2016 at 4:00 P.M., the Director of Nursing indicated Resident #82 received dialysis fistula checks on the days she received dialysis, however the resident did not receive them on days she did not receive dialysis. During a record review on 02/02/2016 at 10:55 A.M., a care plan for Resident #82 indicated "...Check access site daily fistula/graft/catheter - signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills)...." A form titled "DIALYSIS/OBSERVATION COMMUNICATION FORM" indicated Resident #82's fistula was checked on the following dates: 1/18/2016, 1/20/2016, 1/22/2016, 1/25/2016, 1/27/2016, 1/29/2016, and 2/1/2016. 3.1-35(g)(2)			

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F 0309 SS=E Bldg. 00	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. A. Based on observation, record review and interview the facility failed to ensure 3 of 3 residents were administered their insulin via a pen according to the facility's procedure. (Resident #161, #166 and #133) B. Based on interview and record review the facility failed to ensure daily fistula site checks were completed for Resident #82. This had the ability to affect 1 of 2 residents receiving dialysis in the facility. Findings include A.1. During a medication administration observation on 1/27/16 at 5:20 P.M., LPN (Licensed Practical Nurse)#1 did not prime the Humalog KwikPen with 2 units of insulin prior to loading 5 units of Humalog (a rapid acting insulin) for Resident #161. LPN #1 was observed administrating the 5 units of Humalog using the KwikPen subcutaneously into her abdomen.	F 0309	Corrective action for alleged deficientpractice LPN's 1 &2 received a teachable moments skillstraining from the Education Director, documented in their file as a teachablemoment. Res' 161,166,133 have beenmonitored and have not shown ill side effects from alleged deficient practice. Nurses were in-serviced regarding res #82 physicianorders for daily fistula checks. Res #82did not show any signs of ill side effects r/t alleged deficient practice. Identification of other residents with potential to beaffected by alleged deficient practice: 100% audit of medication records were completed to identifyother residents that were diabetic and required insulin. There was no signs of ill side effects fromthose residents. 100% audit completed to identify current dialysispatients. Orders were reviewed to ensurecompliance. Systematic change to ensure that alleged deficientpractice does not	03/03/2016

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	A.2. During a medication administration observation, on 1/28/16 at 11:27 A.M., LPN #2 did not prime the Humalog KwikPen with 2 units of insulin prior to loading 12 units of Humalog (a rapid acting insulin) for Resident #166. LPN #2 was observed administrating the 12 units subcutaneously into his abdomen. LPN #2 did not hold KwikPen onto abdomen for 5 seconds after the insulin was administered to ensure the whole dose was administered. A.3. During a medication administration observation on 1/28/16 at 11:49 A.M., LPN did not prime the Novolog FlexPen with 2 units of insulin prior to loading 10 units of Novolog (a rapid acting insulin) for Resident # 133. LPN #2 was observed administrating the 10 units subcutaneously into his abdomen. LPN #2 did not hold the FlexPen onto the abdomen for 5 seconds. The resident was observed to have a small amount of clear substance run down his abdomen when the FlexPen was immediately removed after the injection. On 1/28/16 at 12:40 P.M., a 'Competency' form regarding insulin pen usage was obtained from the Director of Clinical Education. The form indicated "...12. Dials a test dose of 2 units. Holds		recur: l Nurses will be in-serviced on proper insulin techniquesby 2-29-16. Insulin administration willbe added to the nurse's annual competency checks and placed in the employee's file Nurses will be in-serviced on facility dialysisprotocol. Each unit manager will beresponsible to review with their staffthe dialysis protocol whenever there isa new resident that receives orders for dialysis. How Corrective Action will be monitored to ensure thatalleged deficient practice does not recur: The Education Director will observe 1 nurse per weekadministering insulin to ensure accurate protocol is followed. Results of those observations will be givento the DON who will review and report findings to the QAPI 1 X per month for 6months & until 100% accuracy is obtained with all nurses. Corrective Date 3-3-16	

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	the pen up and taps to bring any bubbles to the top...13. Presses the INJECT button all the way, holds for 5 seconds, and checks that insulin has come out of needle. The dial will return to "0" if this occurs. This step may be repeated up to 4 times to ensure priming...17. Injects dose, keeping needle at 90 *[degree] angle to skin and keeping needle in place for 5 seconds, ensuring dose window reads "0"...18. Releases button after 5 seconds and removes needle...." B. 1. The clinical record review was conducted on 01/28/2016 at 9:53 A.M., and indicated Resident #82 was admitted on 2/6/2015. Her diagnoses included but were not limited to: Malignant neoplasm of thyroid gland, convulsions, essential primary hypertension, end stage renal disease, other specified hypothyroidism, chronic obstructive pulmonary disease, History of falling, Peptic ulcer site unspecified as acute or chronic without hemorrhage or perforation, acute embolism and thrombosis of unspecified deep veins of lower extremity, nontraumatic subdural hemorrhage. During an interview on 02/02/2016 at 4:00 P.M., the Director of Nursing indicated Resident #82 received dialysis fistula checks on the days she received dialysis, however the resident did not			

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	receive them on days she did not receive dialysis. The care plan for Resident #82 indicated "...Check access site daily fistula/graft/catheter - signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills)...." A form titled "DIALYSIS/OBSERVATION COMMUNICATION FORM" indicated Resident #82's fistula was checked on the following dates: 1/18/2016, 1/20/2016, 1/22/2016, 1/25/2016, 1/27/2016, 1/29/2016, and 2/1/2016. 3.1-37(a)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observations, record review and interviews, the facility failed to provide Activities of Daily Living (ADL) care	F 0312	It is thepractice of this facility to provide necessary services to dependent residentsto maintain good nutrition, grooming and	03/03/2016

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	related to nail care for 1 of 6 residents reviewed for Cleanliness, Grooming and Oral care. (Resident #103) Finding includes: On 1/26/16 at 2:36 P.M., Resident #103 nail tips were sharp and jagged. The resident's fingernails had a dark brown substance underneath the nail. On 1/29/16 at 2:14 P.M., Resident #103 nail tips were observed to be jagged and had a brown substance under the nail beds. On 1/29/16 at 1:55 P.M., a review of the clinical record for Resident #103 was conducted. The record indicated the resident was admitted on 2/6/12. The resident's diagnoses included, but were not limited to: vascular dementia, heart failure, atrial fibrillation and anxiety. An Annual MDS (Minimum Data Set) Assessment, dated 12/8/15, indicated the resident's BIMS (Brief Interview for Mental Status) score was 2, severe cognitive impairment. The resident required extensive assist of one person for personal hygiene. A careplan, initiated on 12/10/15, for physical functioning deficit related to self		personal and oral hygiene. Correctiveaction for alleged deficient practice: Res #103'sfingernails were cleaned. How otherresidents with potential to be affected by alleged deficient practice wereidentified: Nursingstaff completed a 100% facility audit on current residents. Nails that were noted to be dirty werecleaned. Systematicchanges made to ensure deficient practice does not recur: Routine nailcare was added to the resident shower sheet , which the aide will beresponsible to sign off and return to the charge nurse for verification. Nursingstaff in-service will be provided to review nail care protocols by 2-29-16. Howcorrective action will be monitored to ensure alleged deficient practice doesnot recur: ManagementTeam members will observe for resident nail care issues during guardian angelrounds 1 x wkly and report to the unit managers any residents who are in needof nail care. Unit Managers will followup to ensure nail care is provided. Guardian angel Round sheets will be turned into the ED so that that maybe reviewed 1 x month in QAPI for trends and educational opportunities.Additional monitoring will be discontinued when QAPI team sees that 100%threshold has been obtain for correction. CorrectionDate:	

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	care impairment indicated the resident required extensive assist with bed mobility, transfers and eating. The interventions included, but were not limited to: encourage choices with care, and nail care weekly and as needed. During an interview, on 1/29/16 at 2:15 P.M., CNA (Certified Nursing Assistant) #5 indicated the resident was dependent on staff to assist her with grooming. A bathing schedule was obtained from the East Unit Manager. The schedule indicated the resident was bathed this month on the following dates: 1/5, 1/7, 1/12, 1/14, 1/18, 1/21, 1/26 and 1/28/16. During an interview, on 1/29/16 at 3:00 P.M., the Unit Manager for the East Unit indicated the resident would have had her nails trimmed and cleaned on her bathing days. The resident's nail's were observed with the East Unit Manager at this time. The resident's nails were dirty and uneven. On 2/1/16 at 3:38 P.M. the Director of Nursing indicated there was no policy regarding nail care. She did provide a procedure for fingernail care. The procedure indicated "...7. Clean under nails with orange stick...8. Clip fingernails straight across, then file in a		3-3-16 -	

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	curve...." 3.1-38(a)(3)(E)			
F 0323 SS=E Bldg. 00	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. A. Based on observation, record review and interviews, the facility failed to ensure hot water temperatures were maintained at a safe level for 3 of 4 nursing units. B. Based on observation and interviews, the facility failed to ensure electrical power strips and extension cords were maintained in a safe manner for 4 of 4 nursing units. Findings include: A.1. During a check of hot water temperatures, conducted on 01/25/16 between 3:00 P.M. - 5:00 P.M., the following elevated water temperatures were noted:	F 0323	It is thepractice of this facility to ensure that the resident environment remains freeof accident hazards as it possible and each resident receives adequatesupervision and assistance devices to prevent accidents. Correctiveaction for alleged deficient practice: The leakingwater heater and the hot water temperatures were corrected within 24 hoursafter the ED was notified of the problems. There were no showers given during the time the water temperatures werehigh. Since the survey, watertemperatures throughout the units have been tracked on a daily basis and remainwithin state and federal guidelines.. Extension cords were removed from rm 423, 420, 419, 415,219,203, 221, 202 and 509	03/03/2016

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	Resident room #512 - 125.2 degrees Fahrenheit Resident room #517 - 123.8 degrees Fahrenheit Resident room #420 - 123.6 degrees Fahrenheit Resident room #425 - 127 degrees Fahrenheit Resident room #434 - 134.6 degrees Fahrenheit Resident room #413 - 130 degrees Fahrenheit Resident room #505 - 130.5 degrees Fahrenheit Resident room #531 - 129 degrees Fahrenheit Resident room #323 - 125.8 degrees Fahrenheit During an interview, on 01/25/16 at 4:00 P.M., the Maintenance Supervisor indicated the facility had just gotten a new water heater system for the South and East nursing units. He also indicated the water heater for the kitchen and laundry area had "sprung" a leak and a plumbing contractor was going to fix the leaking water heater later in the evening. The Maintenance Supervisor indicated he had not checked the water temperatures since last Friday, January 22, 2016. He indicated normally he checked the water temperatures on a daily basis.		Power strips that were identified by the survey team were secured to the wall Identificationof other residents with potential to be effected by alleged deficient practice: The Maintenance Department conducted random water temps rounds x 1 week throughouteach unit and recorded the results in Building Engines Based on these results, water temperaturesare being maintained within state and federal guidelines, therefore no otherresidents were noted to have been affected. A 100% 1 time audit was completed through the building and any extension cords were removed Any power strips found were secured to the walls Systematic change to ensure that alleged deficient practice does not recur: Water tempchecks have been added to the weekend manager duties to ensure that we are capturing temps 7days/wk. The ED will check random water checks1 time a week during facility rounds. Any issues identified will be addressed immediately. Guardian rounds have been implemented daily by management team members Part of the duties are to observe for extension cords and power strips and to remove extension cords and submit work order to maintenance for the power strips to be placed on the wall. The use of extension cords and power strips will be discussed with	

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	The mechanical room was observed, on 01/25/16 at 4:00 P.M. There was water spraying and collected on the floor from the leaking water heater. The water heater which serviced the Southwest and Primrose unit (400 and 500 resident rooms) was noted to be set at 120 degrees Fahrenheit. The water heater system located in a maintenance room, just outside the secured dementia unit doors, which serviced the South and East nursing units (200 and 300 resident rooms) was set at 115 degrees. The Administrator was informed of the elevated hot water temperatures on 01/25/16 at 4:10 P.M. She indicated she was going to suspend all showers for the evenings, have the plumbing contractor check the systems while he was in the building fixing the leaking water heater, and she was going to notify all nursing staff of the elevated hot water temperatures. The Maintenance Supervisor turned down the hot water heater temperatures for the Southwest and Primrose unit water heater and turned on a faucet to drain the hot water which was above the 120 degrees temperature. A recheck of the hot water temperatures, conducted on 01/25/16 at 4:55 P.M. indicated the hot water temperatures on the Southwest (400) and Primrose (500) halls were 91 - 95 degrees Fahrenheit.		residents at admission and then reviewed quarterly with current residents during resident council. howCorrective Action will be monitored to ensure that alleged deficient practicedoes not recur: Temperaturelogs will be reviewed wkly x 4 weeks by the ED. Results of these reviews will be discussed during monthly QAPI meeting 1x month for 3 months. Compliance will be considered when the facility logs reveal 3 months of temperature ratings to be within state andfederal guidelines and therefore, additional monitoring can be discontinued onthe recommendation of the QAPI team. Guardian Round audits are turned into the ED by each manager daily ED will review and will check to make sure maintenance is aware of any cords or power strips that need to be removed. Maintenance Director/designee will check the rooms daily while he is checking the water temperatures for cords and/or extension cords. ED will do room checks wkly times 60 days then once a month for 3 months Results will be reviewed at QAPI once a month for 6 months for further recommendations. Monitoring will discontinue when the facility is able to show 3 months of compliance during room checks.	

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	The hot water temperatures on the South (300) unit were still 126.0 degrees Fahrenheit. The Maintenance supervisor then turned down the hot water temperatures on the water heat which serviced the South (300) unit. At 5:20 P.M. on 01/25/16 the hot water temperature was 120 degrees on the 300 unit. The facility Preventative Maintenance documentation regarding Hot water temperatures indicated the water temptress were to be checked daily. The hot water temperature recordings for January 2016 indicated there were no temperatures obtained on the weekends. The undated facility policy and procedure, titled "Maintaining Water Temperature," was provided by the Administrator on 02/01/16 at 2:30 P.M. The policy and procedure indicated the following: "Water temperatures should be maintained within allowable ranges as regulated by the state." The procedure included: "The following procedures apply to the daily maintenance of water temperature in resident/patient bathroom, showers and other rooms used by resident/patients...1. Check and record water temperature in resident/patient bathrooms, showers, and other rooms used by patients on a daily basis...."			

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	B.1. During the environmental tour of the facility, conducted on 02/01/16 from 10:15 A.M. - 11:30 A.M. with the Administrator, Maintenance Supervisor, and the Contracted Housekeeping Supervisor the following rooms were noted to have one or more power strips lying on the floor in Resident rooms 423, 420, 419, 415, 219, 203, 221, 202 and 509. In addition, there were extension cords hanging in Resident rooms 308 and 202. 3.1-19(r) 3.1-45(a)(1)			
F 0328 SS=D Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review and	F 0328	It is thepractice of this facility to ensure that residents receive	03/03/2016

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	interviews, the facility failed to ensure 1 of 2 staff observed providing tracheostomy care and suctioning followed the procedure to maintain infection control and assess the resident for respiratory status for 1 of 1 residents with tracheostomy reviewed. Findings include: The clinical record for Resident #169 was reviewed on 01/29/2016 at 1:46 P.M. Resident #169 was admitted to the facility, on 12/14/15, with diagnoses, including but not limited to: persistent vegetative state, pulmonary embolism, urinary tract infection, fevers unspecified,cerebral infarction, tracheostomy and acute and chronic respiratory failure. The physician's orders related to tracheostomy care included: "Tracheal Stoma Care q [every] shift Document oxygen saturation every shift. Change inner cannula every shift." During an observation of tracheostomy care, conducted on 02/02/16 at 10:46 A.M., the following was noted: LPN (Licensed Practical Nurse) #33 washed her hands and obtained a towel and suctioning supplies from a closet in the resident's room. She positioned the towel		proper treatment andcare for special services. Correctiveaction taken for alleged deficient practice: Res 169 wasassessed and had no ill effects to alleged deficient practice. otherswere identified with potential to be affected by alleged deficientpractice: How All residents with trac care have potential to be affected withdeficient practice. SystematicChanges in place to ensure deficient practice does not recur: Nursingstaff will be in-serviced on proper technique. Routine trac care inservices will be provided quarterly to the nurses. Howcorrective action will be monitored to ensure alleged deficient practice doesnot recur: DCE willperform random trach observations while nurses are providing care and willoffer coaching as needed to ensure sterile technique is proformed. DCE willreport observations to the QAPI team by filling out audit form and turning itin to the DON. DON will meet with DCE 1xwk to discuss trends and schedule additional training as needed. DON willprovide audit results 1 x monthly times 6 months & until threshold of 100%compliance is met.	

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	across Resident #169's body and placed the tracheostomy supplies on the over bed table. LPN #33 opened the tracheostomy cleaning kit, opened the gloves, located in the kit, and placed a glove on her left hand, She then proceeded to arrange the rest of the items in the kit and realized she had to open the bottle of liquid in the kit and contaminated her gloved hand. She then put on a pair of new gloves on both hands, then using both gloved hands, she removed the oxygen tubing from the resident's tracheal opening and removed the resident's old dressing from about the stoma. During process, Resident #169 coughed and a large about of mucous substance sprayed all over LPN #33's left, gloved hand and was noted dripping off of her gloved hand. LPN #33 continued the cleaning process without changing her gloves. The resident's inner cannula was changed without LPN #33 changing her gloves or maintaining a sterile field while touching the new cannula. During the cleaning process, LPN #34 entered the room to assist LPN #33. After the cleaning process was completed, LPN #33 and #34 were noted to discuss if Resident #169 needed suctioning. LPN #33 then decided to suction Resident #169. LPN #33 washed her hands again, and obtained a suctioning kit, donned both sterile gloves, then with both hands			

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	gathered up the paper wrapping from the gloves and threw the paper in the trash can. She then handled the packaging and the trach suction tubing with her contaminated gloved hands. After connecting the suction machine tubing to the end of the suction catheter, LPN #33 was noted to have the suctioning catheter wrapped around her left hand. She then guided the tubing into the resident's tracheostomy opening with her right hand, applied suctioning and pulled the catheter tubing back out of the resident's tracheostomy opening. The portion of the suction catheter which had been inserted was then wrapped around her right contaminated gloved hand. In between suctioning, LPN #33 rested her right hand, which had the suction catheter wrapped around it, on the towel which had been placed across the resident's body. She repeated the process of suctioning two more times. The current policy and procedure, titled "Trach Care," undated, provided by RN (Registered Nurse) #35 on 02/02/16 at 11:20 A.M., included the following: "...Wear sterile gloves when caring for tube and stoma site..." The procedure for Tracheostomy Inner Cannula Care indicated specific instruction to donn a sterile glove on the nurse's dominant hand just before touching the inner			

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	cannula and stoma. The procedure for Tracheostomy Suctioning indicated the following: "5. Assess respiratory status. 6. Open sterile normal saline bottle 7. Open suction catheter kit. 8..Don sterile gloves. Throughout the procedure the dominant gloved hand should remain sterile and non dominant gloved hand should be kept clean 9. Open sterile container for flushing catheter and pour in sterile normal saline into sterile container with the non-dominant hand. 10. Attach the sterile catheter to suction machine tubing, holding sterile catheter in dominate hand. 11. Turn suction on to a range of 80 - 120 mm Hg [millimeters of mercury] pressure with non-dominant hand. 12. Insert the sterile catheter quick and gently until you feel resistance. Do not apply suction while inserting. 13. With your non-dominant gloved hand cover the suction control opening of the catheter and apply intermittent suctioning as you gently rotate and withdraw the catheter. 14. Do not suction more than 10 seconds at a time. 15. Assess respiratory status. 16. Dip the catheter into the sterile saline to rinse catheter until it is clear of secretions...." After the suctioning process was completed, LPN #33 and 34 discussed the resident's increased "yawning" and a			

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	Biox (oxygen level) was obtained. At no time did LPN #33 or 34 assess the resident's respiratory status. 3.1-47(a)(4) 3.1-47(a)(5)			
F 0329 SS=D Bldg. 00	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. 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. Based on record review and interviews, the facility failed to ensure there was	F 0329	It is the practice of this facility to ensure that each resident's drug regimen is free from unnecessary	03/03/2016

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	adequate indications for the use of an antihistamine and hypnotic supplement for 1 of 5 residents reviewed for unnecessary medications. (Resident #90). In addition, the facility failed to ensure there was adequate monitoring of a medication to treat hyperlipidemia and of an antianxiety medication for 2 of 5 residents reviewed for medications. (Resident #79 and #152) Finally, the facility failed to ensure there were gradual dose reductions of an antipsychotic medication for 1 of 5 residents reviewed for medications. (Resident #152) Findings include: 1. The clinical record for Resident #79 was reviewed on 01/28/2016 at 1:18 P.M. Resident #79 was admitted to the facility, on 09/11/14, with diagnoses, including but not limited to: hyperlipidemia. The current physician's orders for medications include the following: Simvastatin (a medication prescribed for elevated cholesterol levels) 20 mg at bedtime. There was no care plan to address the resident's hyperlipidemia or the use of the Simvastatin.		drugs. Corrective Action for alleged deficient practice: Res 90'medications were reviewed and diagnosis updated to address the use ofantihistamine and hypnotic supplement. Care plan was updated to includediagnosis of Bipolar/PersonalityDisorder. Res 79'scare plan was updated to include the use of medication for hyperlipidemia. Blood test was completed on 2-5-16 andresults sent to the physician. Also,clarification order received for Ativan from the physician and discontinued on2-12-16. Res 152's Zyprexawas decreased on 1-29-16. The care plan was updated to address behaviors/interventions. A blood test was obtained for res #79 to check the resident's liver unction or cholesterol lipid level How other residents were identified that have potential to be affected by alleged deficient practice: SS department completed 100% audit of all residents on psychotropic medications toidentify any residents appropriate for GDR The nursing staff conducted a 100% audit of lab orders & developed a tracking tool that will be utilized to make sure labs are drawn as required and ordered by the MD SystematicChange to ensure alleged deficient practice does not recur. Trackingform was changed to include resident's name, diagnosis, current medication andmost recent date	

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	There was no blood test to ascertain the resident's liver function or cholesterol lipid level in the past 12 months. During an interview, on 02/01/16 at 10:40 A.M., RN (Registered Nurse) #36, the Unit Manager indicated she could not locate any lipid or liver function test for Resident #79 and she had placed a call to the physician to ask if he wanted to order the blood monitoring tests. She indicated the MDS (Minimum Data Set) coordinator was responsible for care planning. During an interview on 02/01/2016 at 2:13 P.M., RN #31, the MDS coordinator indicated the facility did not necessarily care plan those (hyperlipidemia) conditions. 2. On 1/28/16 at 10:27 A.M., a review of the clinical record for Resident #152 was conducted. The record indicated the resident was admitted on 7/10/14. The resident's diagnoses included, but were not limited to: dementia with behavioral disturbance, type 2 diabetes mellitus, problems related to psychosocial circumstances, hypertension, anxiety disorder, edema, restlessness, agitation and psychotic disorder. A Quarterly Minimum Data Set (MDS)		of last GDR and results. SSD will also keep a visual working calendar which will be shared withthe behavioral team during behavior committee meetings. New residents will be assessed and added onadmission. Previous residents will bereviewed along with quarterly MDS assessment to ensure GDR's are not missed. Unit Managers will be responsible to audit admission records within 48 hrs to ensure appropriate labs are ordered. New orders will be reviewed during the daily start-up nursing meetings (mon-fri) Orders received on the weekends will be reviewed at start-up on Mondays Social Service and Nursing staff were in serviced to new system changes. How system change will be monitored to ensure alleged deficient practice does not recur: SSD willreview 4 residents per week for 90 days who are currently taking antipsychotic medicationsfor possible drug reductions and make referrals to behavior committee as appropriate.The DON/ADON will review the list of residents taking antipsychotic medications1x month for 90 days . Results of thosereviews will be shared with QPAI team during QAPI for recommendations todecrease % rate of use of those medicaions. The QAPI team can discontinue monitoring when the facility shows thatall GDR's have	

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	155685		02/02/2016

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	Assessment, dated 12/23/15, indicated the resident's Brief Interview Mental Status (BIMS) was 14, normal cognition. The behavior section indicated the resident had no psychosis (hallucinations/delusions) and the medication section indicated the resident received an antipsychotic, antianxiety and a diuretic medication, 7 days a week. The Medication Administration Record (MAR) indicated the resident was being administered the following medications: Ativan 0.5 milligrams (mg) at bedtime for behavior disturbance (the Ativan was discontinued on 1/27/16) and olanzapine (Zyprexa) 15 mg at bedtime for behavioral disturbances. A Careplan for potential drug complications, revised on 12/31/15, indicated the resident's use of an antipsychotic medication. The interventions included but were not limited to: monthly pharmacy review, observe for side effects of antipsychotic medication and reduction plan as recommended by physician/pharmacist. An Order Summary Report, dated 1/6/16, indicated Lorazepam (Ativan) 0.5 mg was ordered on 11/12/14 with a start date of 11/12/14. The Olanzapine (Zyprexa) 15 mg was ordered on 7/10/14 and		been 100% completed for 3 months without missing any. Nursing will maintain a lab monitoring tracking form, along with resident lab schedule and will be responsible to add and discontinue lab orders as appropriate The nursing designee will audit the lab orders once a month for 90 days and then once a quarter for 4 quarters Results of the audits will be turned into the ADON who will randomly audit 3 resident lab orders and compare to medication records to ensure that required labs are in place These audits will be completed on a monthly basis for 90 days and then once a quarter for 4 quarters Results of the audits will be discussed once a month in QAPI for 90 days and then quarterly thereafter Discontinuation of additional monitoring will be considered when facility audits achieve benchmark of 100% accuracy	

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	started on 7/10/14. A Progress Note-General Note, dated 1/27/16, indicated "...Ativan d/c'd [discontinued] related to pharmacy recommended dose reduction...." Another General Note, dated 7/9/15, indicated "...MD [Medical Doctor] orders to continue with Zyprexa 15 mg daily, rejected pharmacy suggestion to decrease dose to 10 mg daily, pharmacy notified. A Clinical Pharmacist Letter to Physician Services, dated 6/25/15, indicated the Pharmacist recommended a gradual dose reduction for Zyprexa 15 mg a day to 10 mg a day. The recommendation was rejected with no clinical rational documented on the form as requested. Another pharmacist recommendation, dated 1/25/16, indicated a dose reduction of the Ativan 0.5 mg daily to 0.25 mg daily. At the bottom of the phone was written "...per phone order - D/C [discontinue] Ativan 1-27-16...." Another pharmacist recommendation, dated 1/25/16, indicated a reduction of the Zyprexa 15 mg daily to Zyprexa 10 mg daily. The physician accepted the recommendation on 1/28/16. During an interview, on 1/28/16 at 3:11 P.M., the Social Service Director indicated there were no behaviors or			

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	interventions for Resident #152. She further indicated the physician reduced the Zyprexa dosage today. On 1/29/16 at 9:40 A.M., the Social Service Director provided a policy titled "Medication Monitoring Medication Management", dated August 2014, and indicated the policy was the one currently used by the facility. The policy indicated "...Antipsychotics. If a resident is admitted on an antipsychotic;tic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR [Gradual Dose Reduction] in two separate quarters (with at least one month between attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated...." During an interview, on 1/29/16 at 9:50 A.M., the Social Service Director indicated she could not find any other gradual dose reduction recommendations from the pharmacist for the Ativan or Zyprexa prior to July of 2015. 3 A clinical record review was conducted on 01/28/2016 at 9:56 A.M., and indicated Resident #90 was admitted on 11/14/2014. His diagnoses included but were not limited to: Bipolar disorder,			

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	chronic obstructive pulmonary disease with acute exacerbation, bipolar disorder current episode mixed moderate, personality disorder, obesity, nicotine dependence uncomplicated, heart disease , alcohol dependence uncomplicated, essential primary hypertension, type 2 diabetes mellitus without complications, polyosteoarthritis, arteriosclerotic heart disease of native coronary artery without angina pectoris, presence of aortocoronary bypass graft, end stage renal disease, gastro-esophageal reflux disease without esophagitis, hypothyroidism unspecified, and hyperlipidemia. A record review was conducted on 01/28/2016 at 9:56 A.M., and indicated the following: An order for Melatonin (a sleep aid medication) Tablet 5 MG (milligrams)"...by mouth at bedtime for supplement...." An order for Benadryl Tablet (an antihistamine) "...Give 50 mg by mouth every 8 hours as needed for itching/nerves...." During an interview on 02/1/2016 at 10:00 A.M., Unit Manager # 11 indicated Resident #90 was readmitted to the			

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	facility with an insomnia diagnosis which had not been transcribed over from the hospital records. She further indicated Resident #90 did not have a care plan for his diagnoses of Bipolar, Personality disorders, insomnia, or for his itching/nerves. During an interview on 02/02/2016 at 10:00 A.M., Social Service employee #12 indicated Resident #90 did not have any behavior care plans or documentation related to his orders for Melatonin and Benadryl. During an interview on 2/1/2016 at 11:10 A.M., Unit Manager #11 indicated Resident #90 did not have a supporting diagnosis for the Benadryl medication.. She further indicated that Resident #90 was ordered Benadryl for Anxiety. 3.1-48(a)(6) 3.1-48(b)(2)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and	F 0332	It is thepractice of this facility to be	03/03/2016

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	interview, the facility failed to ensure a medication error rate of less than 5 percent for 2 of 9 residents observed during medication pass. Two (2) medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 8 percent. There were 25 opportunities with 2 errors resulting in a 8 percent (%) medications errors rate. This related to 2 of 3 residents not receiving a meal within 15 minutes after being administered a rapid acting insulin injection. (Resident #161 & Resident #166) Findings include: 1. During a medication administration observation on 1/27/16 at 5:20 P.M., Resident #161 was given 5 units of Humalog (a rapid acting insulin) subcutaneously into her abdomen by LPN (Licensed Practical Nurse) #1. The resident's blood sugar check prior to administration of the Humalog was 192. On 1/27/16 at 5:42 P.M. Resident #161 had not received her evening meal hall tray and was observed in her room watching TV. During an interview, on 1/27/16 at 5:50 P.M., LPN #1 indicated the hall trays		free of medication error rates of 5% or more Correctiveaction for alleged deficient practice: Res 161& 166 had no ill effects from alleged deficient practice. LPN 1 & 2 were re-educated by the staffEducation director regarding proper technique of administering Insulins. Howothers were identified with potential to be affected by alleged deficientpractice? All residentsreceiving insulin have the potential to affected by this practice. SystematicChange to ensure alleged deficient practice does not recur: Snacks willbe kept on the med carts and will be offered to the resident after the insulinhas been given by the nurses. Nurses willreceive in service training and will be required to complete returndemonstration with the staff educator. Howsystem will be monitored to ensure alleged deficient practice does not recur? DNS/ADON ordesignee will do random observations 3 x wkly for 4 weeks, then 1 time wkly for4 wks, then 1 time monthly to ensure proper administration. Results will be tracked on a audit tool thatwill be taken to QAPI 1 time a month for 3 months & until threshold of 100%is met.	

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	arrive to the unit after the residents are served in the dining rooms and trays should arrive to the unit by 6:00 P.M. On 2/1/16 at 3:40 P.M., a review of the clinical record for Resident # 161 was conducted. The record indicated the resident was admitted on 1/25/16. The resident's diagnoses included, but were not limited to; acute respiratory failure, acute kidney failure and type 2 diabetes. 2. During a medication administration observation, on 1/28/16 at 11:27 A.M., Resident #166 was given 12 units of Humalog (a rapid acting insulin) subcutaneously into his abdomen by LPN #2 while the resident was in his room. The resident's blood sugar prior to the administration was 298. On 1/28/16 at 11:45 A.M., Resident #166 was observed in his room, sitting in a wheel chair facing the hallway. On 1/28/16 at 11:58 A.M. Resident #166 was observed being propelled by a staff member from his room and down the hallway toward the dining. On 2/1/16 at 3:50 P.M., a review of the clinical record for Resident #166 was conducted. The record indicated the resident was admitted on 10/12/15. The			

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	resident's diagnoses included, but were not limited to: dementia, depressive disorder, seizures, and type 2 diabetes. On 1/28/16 at 1:00 P.M., the Director of Nursing provided a policy titled "Diabetes Management," dated 12/8/14, and indicated the policy was the one currently used by the facility. The policy indicated "...Rapid Acting Insulins [Humalog]...In general, administration must occur within 15 minutes of mealtime due to rapid action...." 3.1-25(b)(9) 3.1-48(c)(1)			
F 0334 SS=B Bldg. 00	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time			

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	period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an			

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	assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on interview and record review, the facility failed to ensure 5 of 5 residents reviewed for administration of Influenza and Pneumococcal vaccinations received annual education. (Residents #8, 78, 32, 46 and 115) Findings include: During a record review, on 02/022016 at 9:39 A.M., a form titled "Update Immunization" indicated that Residents #8, #78, #46, #32, and #115 did not receive education regarding the Influenza vaccine prior to consent or refusal. During an interview on 02/02/2016 at 9:45 A.M., the Director of Nursing indicated the residents receive education upon admission and are then asked annually if they consent or decline. She further indicated there was no documentation of annual education being provided to the residents concerning the Influenza vaccination. On 02/02/2016 at 9:39 A.M., the Director	F 0334	It is thepractice for this facility to provide annual education of influenza andpneumococcal vaccinations. How allegeddeficient practice was corrected: The CDCinformation sheet for education of risks/benefits of the influenza vaccine wasmailed to families and residents 8,78,32,46 and 115. A copy of the informational sheet wasattached to the previous consent that was obtained prior to giving out shots. How other residentswere identified that have potential to be affected: Allresidents have potential to be affected. Informational letters were mailed toresidents and their family members. Systematicchange to ensure deficient practice does not recur: Consentforms, along with the CDC informational sheet will be mailed to thefamily/resident with a stamped return envelope prior to administration of thevaccinations. Consent forms will bemaintained in a binder in the nurses office for quick reference.	03/03/2016

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	of Nursing provided a policy titled "Influenza/Pneumococcal Immunization Guideline," dated 11/02/2015. The policy indicated "...Current Residents The resident and/or responsible party will sign the Resident Annual Immunization Consent or Declination Form each year as proof that education of risks/benefits was provided on the influenza vaccine...." 3.1-13(a)		How systemwill be monitored to ensure alleged deficient practice does not recur: MedicalRecords will review all copies of consents to make sure the information formwas provided on a monthly basis for any resident that receives the shot. Results will be kept on a audit log whichwill be turned into the DON for further review. Logs will be taken to the QAPI meetings on monthly basis x's 3 monthsuntil 100% threshold is reached .	
F 0364 SS=E Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interviews and record review, the facility failed to serve food at the proper temperature at point of service. This had the potential to affect 1 of 15 resident's that received hall trays on the Primrose hallway, 1 of 28 resident's that received hall trays on the South hallway, and 1 of 38 resident's that received hall trays on the East hallway. (Resident #85, Resident #177 and Resident #206)	F 0364	It is the policy of this facility to provide food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature Corrective Action taken for alleged deficient practice: Res #85, #177, #206 were offered new trays Facility ordered replacement doors for the insulated carts to use to help maintain temperature Identification of other residents that have potential to be effected	03/03/2016

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	Findings include: During an interview, on 1/25/16 at 11:50 A.M., Dietary Aide #8 indicated the residents on all of the units that receive room trays complain about the food being served cold. She further indicated the Dietary department has an insulated cart but the staff never use it and she was unsure why. She indicated at times after the trays are "set up" they are placed in an uninsulated metal cart for a long time before being sent out on the units to be served. She further indicated once the carts are delivered to the hallways they might set for a while before they are served when the staff are busy. On 1/26/16 at 8:20 A.M., Resident #179's tray sat for 15 minutes in an open metal cart before being served to her. Once her meal was served the resident indicated her egg casserole was cold. During an interview, on 1/26/16 at 11:45 A.M., Resident #123 indicated her mashed potatoes were cold and requested the staff bring her warm potatoes. During an interview, on 1/26/16 at 12:00 P.M., Resident #7 indicated her food is always cold. On 1/28/16 at 11:10 A.M., the steam		by alleged deficient practice: Dietary manager attended facility food committee and reviewed current grievances to see if anyone was complaining about food temperatures Systematic changes to ensure that alleged deficient practice does not reoccur: Hall trays will be delivered in insulated charts to assist with maintaining temperatures Plate warmers, pellets and steam tables will be turned on 30-60 minutes prior to the start of meal services Unit managers and social services will meet with hall tray residents to encourage them to come to dining rooms for meal services Meal times were changed to allow more time for residents to get ready for meal service Unit managers will be responsible to ensure that hall trays are distributed immediately once they are delivered from dietary Dietary staff will receive training on food palatability and preparation by 2/29/16 How corrective action will be monitored to ensure that alleged deficient practice does not reoccur: Dietary manager/designee will check food temps and meal timeliness daily x4/weeks and record results on meal temp monitoring forms, then 1x weekly for 90 days to ensure food is being served at appropriate temps DM/Designee will interview 3	

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	table food temperatures in the main kitchen was observed: Chicken pot pie 166 degrees Fahrenheit (F), green beans 187 degrees (F), puree chicken 142 degrees (F), puree vegetables 126 degrees (F), gravy 160 degrees (F), mashed potatoes 129 degrees (F), corn 193 degrees (F), peas 191 (F), tomato soup 156 degrees (F), chili 119 degrees (F), hot dogs 161 degrees (F), chicken tenders 165 degrees (F) and hamburgers 192 degrees (F). On 1/28/16 at 11:35 A.M., an observation indicated the lunch trays were to be delivered to the South hallway at 11:45 A.M., the trays were loaded onto the cart for delivery at 11:50 A.M. and arrived on the hallway at 11:55 A.M. The staff started to deliver the trays at 12:10 P.M. The last tray on the cart was for Resident #85 and was passed at 12:16 P.M. The Dietary Manager checked the temperature of the tray for Resident # 85 at 12:20 P.M. The temperature of the green beans and the chicken pot pie was 126 degrees (F). There was nothing else served on the tray. On 1/28/16 at 11:45 A.M., an observation indicated the lunch trays were to be delivered to the East hallway at 12:00 P.M., the trays were delivered to the		residents per week for 4 weeks, then 1 resident per week for 90 days The DM will meet 1x/week with the ED for 4 weeks to review results of t he resident interviews and food committee Results of the audits will be taken to QAPI 1x monthly for 6 months and/or threshold of 100% compliance is obtained DM/Dietician will attend monthly resident food committee 1x/month	

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	hallway at 11:45 A.M. The last tray on the cart was for Resident #177 and was passed at 12:15 P.M. The Dietary Manager checked the temperature of the tray for Resident #177 at 12:25 P.M. The temperature of the chicken pot pie was 122 degrees (F), the green beans was 121 degrees (F) and the pudding was 52.9 degrees (F). On 1/28/16 at 12:05 P.M., an observation indicated the lunch trays were to be delivered to the Primrose hallway at 12:30 P.M., the trays were started to load onto the cart in the kitchen at 12:05 P.M. and were taken to the hallway at 12:30 P.M. The last tray on the cart was for Resident # 206 and was passed at 12:35 P.M. The Dietary Manager checked the temperature of the mechanical soft food for Resident #206 at 12:45 P.M. The temperature of the chicken pot pie was 138 degrees (F), green beans 109 degrees (F) and the pudding was 61 degrees (F). During an interview, on 1/28/16 at 12:45 P.M., the Dietary Manager indicated she likes to see hot food served above 130 degrees. On 2/1/16 at 9:30 A.M., the Dietary Manager provided a policy titled "Holding and Serving," dated 2011, and indicated the policy was the one currently			

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	used by the facility. The policy indicated "...Mechanically altering foods (including puree foods) increases the potential hazard and must be held at 135 degrees F or above for hot food, and 41 degrees F or below for potentially hazardous cold foods...Holding potentially hazardous food (PHF) hot foods: Hold hot foods at a continuous temperature of 135 degrees F or above on the serving line or according to state regulations...reheat immediately to 165 degrees F for 15 seconds any hot food that falls below 135 degrees F...Hold potentially hazardous cold foods at a continuous temperature of 41 degrees or below. Hold all potentially hazardous cold items on ice during service or remove only small amounts of chilled items, such as pudding, assuring that temperature is maintained at 41 degrees or below...Deliver food carts immediately after being loaded from meal line to the dining area or unit...." 3.1-21(a)(2)			
F 0371 SS=F Bldg. 00	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			

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	local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interviews, the facility failed to ensure food was stored, served and prepared in a sanitary manner in 1 of 1 kitchen and 4 of 4 nourishment refrigerators. This potentially affected 145 of 147 residents who consumed food in the facility. In addition, the facility failed to prepare and distribute hall trays under sanitary conditions on 2 of 4 hallways. This had the potential to affect 19 of 19 hall trays that were delivered to the Southwest and Primrose Unit. Findings include: 1. On 1/25/16 from 10:45 A.M.-11:20 A.M., the initial kitchen tour was conducted with the Dietary Manager and the following was observed: Two metal cookie sheets were stored on a shelf as clean, both cookie sheets had a tan sticky substance along the edges of them. Two plastic spatulas were put away in a drawer as clean, both spatulas had a brown dried substance on them. Three metal steam pans were stored on a shelf as clean both pans had a brown sticky substance on the edges of them. Two plastic cutting boards were stored on a	F 0371	F 371 (Food Storage/SanitaryConditions) It is thepractice of this facility to ensure food is stored, served and prepared in asanitary manner. It is also the practiceof this facility to prepare and distribute hall trays under sanitaryconditions. CorrectiveAction for alleged deficient practice: Dishes,cooking pans and cooking utensils have been cleaned and inspected before beingput away. Microwave has been cleaned.The steam table was cleaned. Thedelivery carts were cleaned and the nutrition pantries on each hall werecleaned. A thermometer was put in South Nutrition refrigerator. The rubbergasket on East Hall refrigerator has been repaired. Lids havebeen put on the ice scoops next to the ice machines. The coffeecontainers have been cleaned and removed from the floor. Thebaseboard in the kitchenette has been replaced. Gaskets havebeen replaced on the nutrition pantry refrigerator. Hall trayson being delivered in closed, insulated carts. Identificationof other residents with potential to be affected by alleged deficient practice: Sanitationrounds were done by the Dietician . Audit results were shared	03/03/2016

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	metal rack as clean, both had a dried brown substance on the edges of them. The microwave had a greasy film on the outside of it as well as food splatter on the outside of it. The metal steam table had a dried red substance on the counter top edges. A metal cart used to deliver hall trays was observed to have a brown sticky substance on the sides and bottom of the cart, the end of a long cotton string was observed sticking to the edge of the cart and the other end of the string was dragging on the floor as the cart was pushed. A large metal coffee urn was observed on a counter top approximately 3 feet from the floor. Dietary Aide #8 was observed placing an insulated coffee container on the tile floor under the coffee urn and proceeded to fill the coffee container on the floor, she then moved the coffee container on the floor with her shoe, she then picked the coffee container up off of the floor and loaded it onto a metal cart to take to the dining room for service. Two soiled linen napkins were rolled up and placed on top of 3 soiled plates and 3 glasses half full of milk on a small counter top located right outside of the main kitchen entry door in the garden lounge. At the bottom of the cabinets in the kitchenette area of the garden lounge the base board was missing from an area approximately 8 inches in diameter, which exposed crumbling plaster/drywall		with staff to develop a plan forcorrection. Systematicchanges to ensure that alleged deficient practice does not recur: Dietary staffwill attend 1 in-service per month that will address proper cleaningtechniques, sanitation overview , cross contamination, and submission of workorders in building Engines. They willalso receive training regarding safe delivery of food and covering opencontainers. A Unit Audittool has been developed in which the DM/Designee will complete once a week andturn into the ED, which will focus on sanitary rounds in the dietary departmentand cleaning of the the nutrition pantries on the halls. How correctiveaction will be monitored to ensure alleged deficient practice does not recur: The DietarySupervisor will monitor meal service and distribution using test tray form withmeal times varying between breakfast, lunch and dinner 5 x wk (mon-fri) for 4weeks, then 3 X's wk for 4 weeks, then 1 x wk for 4 wks for a total of 12 weeksmonitoring. SanitationRounds will be conducted by DM/Designee 2 times wkly and turned into the ED forreview. ED and DM will meet 1 time a week for 90 days to review the results ofthe audits and to formulate action plan to address any trends identified. ED will then review audit results with QAPIteam 1xmonth for 3 months for	

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	and wood. Two ice machines were located outside of the main kitchen entry door. Two ice scoops were observed in plastic containers with no lids. The outside of both ice machines had a white scaly film on them. On 1/28/16 from 10:45 A.M.-12:15 P.M., the following was observed during the second kitchen revisit: Six metal serving carts used to deliver hall trays were located in the room adjacent to the dish room. All 6 carts were lined up to have hall trays loaded onto them during meal service. All 6 carts were observed to have a brown sticky substance on the sides and bottoms of the cart. One metal cart continued to have a long cotton string sticking to the side of it and the string dragged on the floor as it was pushed to be loaded with trays. The Dietary Supervisor was notified of the soiled carts and an unidentified dietary aide cleaned the carts before loading hall trays onto them. On 2/1/16 from 11:00 A.M.-11:25 A.M., an observation of the nourishment refrigerators was conducted and the following was observed: At 11:00 A.M., on the South unit the bottom shelf of the refrigerator and the		recommendations to continue or discontinueadditional monitoring. Compliance willbe considered to be met when facility audits will be at 100% compliance withcleaning techiques.	

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	floor under the refrigerator had a red sticky substance on it. There was no thermometer located in the freezer. At 11:10 A.M., on the East unit the freezer had a brown sticky substance in it. The shelves inside the refrigerator had a brown sticky substance on it. The rubber gasket at the bottom of the refrigerator door was ripped half way off which allowed the gasket to drag on the floor when the door was opened. A black/brown sticky substance with hair was observed on the gasket as it dragged across the floor when the door was opened. At 11:20 A.M., on the Primrose unit the refrigerator had a tan sticky substance on the inside of the door, the shelves and at the base of the refrigerator. At 11:25 A.M., on the Southwest unit there was a brown sticky substance on the glass shelves and on the drawers. There was an open can of Pepsi in the door of the refrigerator there was no name and no date on the can. The gasket at the bottom of the refrigerator door had a rust colored sticky substance on it. A temperature log was taped on the front of the freezer, no refrigerator temperatures were documented for 1/29/16, 1/30/16 and 1/31/16.			

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	During an interview, on 2/1/16 at 11:30 A.M., the Dietary Manager indicated the dietary department stocks the nourishment refrigerators with drinks and snacks but it is the nursing departments responsibility to clean and check the temperatures for the nourishment refrigerators and freezers. On 2/2/16 at 9:30 A.M., the Dietary Manager provided a policy titled "Cleaning Reach in Refrigerators and Freezers", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Clean leaks and spills as they occur...Follow the steps below weekly to clean reach-in refrigerators and monthly to clean reach-in freezers:.. 2. Remove shelves, wash and sanitize using a soft bristle brush if necessary. 3. Wash the inside of the unit thoroughly with warm water and detergent. 4. Rinse with a sanitizing solution following manufacturer's directions for proper strength...6. Wash outside thoroughly with warm water and detergent. making sure to clean gaskets with warm water and detergent. Note: Gaskets must be free of mold and in good repair at all times...." On 2/2/16 at 10:30 A.M., the Dietary Manager provided a policy titled			

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	"Sanitation Overview", dated 2/12/15, and indicated the policy was the one currently used by the facility. The policy indicated "...The director of dining is responsible for training, monitoring proper sanitation techniques and compliance...(A) Equipment food-contact surfaces and utensil shall be clean to sight and touch. (B) The food contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris...." 2. During a Rosewood Dining Area observation, on 1/29/16 at 8:05 A.M., CNA (Certified Nursing Assistant) #15 was observed filling glasses with milk and juice and sitting them on top of a tray cart. The observed cart had slots and in the slots were empty meal trays and the cart had no doors on it. The meal trays were observed to have wet areas on them. CNA #15 proceeded to place take the uncovered glasses with milk and juice from the top of the cart and place the filled glasses on the meal trays. QMA (Qualified Medication Aide) #16 was observed placing silverware, rolled in a napkin, on each meal tray. QMA #16 was observed taking a paper towel and wiping off the wet areas on each tray, however			

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	he did not replace any of the silverware napkin rolls. At 8:15, CNA #15 was observed placing a bowel of uncovered cereal on each meal tray, on the cart. At 8:20 A.M., CNA #15, CNA #17, QMA #16 and LPN #4 were observed taking a breakfast plate, containing french toast sticks and bacon, from the serving area kitchenette and placing it on a plastic plate holder, without a heating element, and covering plate with a plastic lid. At 8:25 A.M., CNA #15 was observed pushing the open cart towards the Southwest and Primrose Units which contained 19 meal trays with juice, milk and cerebral uncovered. On top of the cart were 5 glasses of milk, 3 glasses of juice and 3 bowels of cereal uncovered. On 1/29/16 at 8:25 A.M., Cook Aide #18 came toward the cart and indicated the hall trays were for the Primrose and Southwest Unit. Cook Aide #18 further indicated all hall trays for all 3 meals were prepared from the Rosewood steam table kitchenette area and distributed throughout the East, Primrose and Southwest Units on a similar cart. Cook Aide #18 further indicated the East Unit didn't have any hall trays this morning due to the men's club breakfast had been served earlier in the Activity Area. Cook Aide #18 indicated the process was changed about 2 months ago.			

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	During an interview, on 1/19/16 at 8:30 A.M., Kitchen Aide #19 indicated the plates used for the hall trays were not placed on a plate warmer prior to breakfast items being placed on them. The plates were observed in the kitchenette lying on top of the microwave. She further indicated the milk, juice and cereal was distributed on an open cart and uncovered as the cart was going down the hallway. On 2/1/16 at 9:30 A.M., the Food Service Manager provided a policy titled, "Holding and Serving", dated 2011, and indicated the policy was the one currently used by the facility. The policy indicated "...Food delivery carts...Make sure divided hot and cold carts are working properly and plugged in prior to start of loading with sufficient time to have achieved correct unit temperatures...Do not preset food carts with cold items before the start of meal service or before the cart is to be loaded...Deliver food carts immediately after being loaded from meal line to the dining area or unit...." On 2/1/16 at 10:25 A.M., the Food Service Manager provided a policy titled "Nursing Responsibilities at Meal Service", dated 2011, and indicated the policy was the one currently used by the			

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	facility. The policy indicated "...Distribution...All food must remain covered or in an enclosed cart while being distributed through the hallways...." This federal tag relates to Complaint IN00190501. 3.1-21(i)(2) 3.1-21(i)(3)			
F 0412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review and interviews, the facility failed to ensure routine dental care was provided timely for 2 of 3 residents reviewed for dental needs. (Resident #123 and 103) Findings include:	F 0412	It is the practice of this facility to provide or obtain from an outside resource in accordance with 48375(h) routine and emergency dental services to meet the needs of the residents The facility currently has a contract with Senior Dental Care Corrective action for alleged deficient practice: Res 123 has a dental	03/03/2016

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	1. The clinical record for Resident #123 was reviewed on 01/28/2016 at 2:05 P.M. Resident #123 was admitted to the facility on 02/13/15 with diagnoses, including but not limited to: fracture of the left femur, diabetes mellitus, encephalopathy, polyosteoarthritis, chronic obstructive pulmonary disease, generalized anxiety, history of falling, pain, and acute embolism and thrombosis of the deep veins. On 01/26/2016 at 01:59 P.M., Resident #123 was observed sleeping in her wheelchair in the cafe lounge. Her dentures were noted to have fallen completely out of her mouth and were laying on her chest. On 01/28/2016 at 3:12 P.M., Resident #123 was observed in her wheelchair in the cafe lounge watching television. She was noted to have upper dentures in place, but no lower dentures. She indicated her lower dentures were "at home" in a drawer. She indicated they did not fit and she hoped the facility was getting her new ones. The admission MDS (Minimum Data Set) assessment, completed on 02/24/15 indicated the resident did not have natural teeth but did not have any ill fitting or missing dentures. During an interview		appointment on 3-2-16 to be assessed for possible new dentures Res 103 was seen by the dentist 2-3-16 and was not appropriate for placement of dentures No health issues were identified and resident has no difficulty eating at this time How other residents were identified to have potential to be affected by alleged deficient practice: 100% audit was completed through interviews and chart review Residents who were agreeable to see the dentist was referred for services Systematic changes to ensure alleged deficient practice does not recur: Dental services Information has been added to the admission packet It will be the admission director's responsibility to review with the resident/family and have the acknowledgement signed A copy of the acknowledgement will be kept in the financial folder and on the medical record Staff will use a social service referral form to communicate to the social service director who will then be responsible to arrange the service How the system will be monitored to ensure alleged deficient practice does not recur: The social service director will maintain a current log of all residents and their last dental service/visit The log will be taken to the care plan meetings and reviewed for any residents who haven't seen the dentist within timely period and/or who have	

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	with LPN #4, the unit manager, on 01/29/2016 at 9:58 A.M. she indicated the assessment was inaccurate. The most recent quarterly MDS, completed on 12/15/15 indicated she had no ill fitting or missing dentures. The health care plan regarding Activity of Daily Living (ADL's), current through 03/22/16, included the following intervention: "Oral care bid (twice a day) and PRN (as needed). Has upper dentures. Dental exams as necessary." During an interview on 01/29/16 at 9:56 A.M., the SSD (Social Service Director), Employee #32, indicated Resident #123 was not seen by an in house dental services and there was no outside dental exam in her chart since she was admitted to the facility in February 2015. Employee #32 indicated she had not contacted the family regarding any denture issues or the need for routine dental care. During an interview with the Unit Manager, LPN #4, on 01/29/16 at 9:58 A.M., she indicated when the resident was admitted she only had upper dentures and she had not notified family regarding any denture issues as the resident had not complained of any issues.		dental needs The social service director will follow up with the patient to see if the patient would like the service and make the referral accordingly The Medical records department will randomly audit 10 charts a week for 4 weeks to confirm that residents have dental notes on their medical records The ED will meet 1 time a month for 3 months to discuss any trends that have been identified Non-compliance issues will be directed to the QAPI team 1 x month for 3 months Additional monitoring may be discontinued when facility has consistently shown 3 months of 100% compliance with dental referrals	

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	Further interview with SSD , Employee #32, on 01/29/16 at 10:00 A.M. indicated routine dental services were set up on admission if the resident or family requested the service but the in house dental services were not offered to Medicare or Medicaid residents as part of the Admission process. There was no documentation of any refusal of in house dental services. Employee #32 indicated most residents and families elected not to select in house dental services because of the "liability" charge. Employee #32 indicated there was a charge, which came out of the resident's liability, to pay for the dental services. Further discussion indicated the charge did not impact the personal monies of the Medicare or Medicaid residents, but rather the amount the facility received from either Medicare or Medicaid. It was unclear if the covered service was presented to resident's and families in a manner which was clear as to the charge for the service. There was no documentation of refusal of in house dental services for Resident #123. There was also no documentation social services or nursing had made Resident #123's family aware of any dental needs. Employee #32, who had been present during the previous observation of Resident #123 when her upper dentures had fallen completely out			

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	of her mouth, indicated she was not aware of any issues. 2. On 1/29/16 at 1:55 P.M., Resident #103 was observed to have no teeth or dentures. On 1/29/16 at 1:55 P.M., a review of the clinical record for Resident #103 was conducted. The record indicated the resident was admitted on 2/6/12. The resident's diagnoses included, but were not limited to: vascular dementia, heart failure, atrial fibrillation and anxiety. A careplan, initiated on 12/10/15, for physical functioning deficit related to self care impairment indicated the resident required extensive assist with bed mobility, transfers and eating. The interventions included but were not limited to: encourage choices with care, oral care assistance, dental exams as necessary and resident had dentures, but doesn't always wear them. An Annual Minimum Data Set (MDS) Assessment, dated 12/8/15, indicated the resident required extensive assistance of one person for personal hygiene. The oral/dental section indicated the resident had no natural teeth. A dental exam, dated 11/14/12, indicated			

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	the resident was missing her teeth and had dentures. The dentist's evaluation indicated the following: cleanse dentures, dentures fit well and no complaints or concerns. A form titled "Resi-Dent Application for Limited Benefit In-Facility Dental Policy," dated 8/21/12, indicated the applicant was Resident #103, premium was $60.00 and authorization was a verbal consent. During an interview, on 1/29/16 at 3:05 P.M., the Social Service Director (SSD) indicated the resident had an initial complementary dental exam in 2012 and had had no other dental exams, as the Resident's representative opted out of dental exams. The SSD provided an Activity History from the Customer Service/Sales representative, dated 9/7/12. The Activity History further indicated the resident's responsible party was called to ask if wanted the "dental program" for the resident. The Activity History indicated a call back was not received from the resident's representative. The SSD had no further documentation regarding denial of dental care from the resident's responsible party. 3.1-24(a)(1) 3.1-24(a)(3)			

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F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except			

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	when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, record review and interview, the facility failed to ensure the the facility procedure was implemented related to the dating of vials when opened. This affected 1 of 4 nursing units. . Finding includes: On 1/27/16 at 4:42 P.M., the medication refrigerator on the Southwest Unit was observed with LPN (Licensed Practical Nurse) #4. The refrigerator had an open vial of Tuberculin Purified Protein (TB vaccine) and an open vial of Afluria (Influenza Vaccine). Both vials did not have an open date recorded on the box or vial. LPN #4 was unable to verify an open date for either vials thru the facility's pharmacy. LPN #4 indicated the vials would be expired 30 days from an open date. She further indicated she would dispose of the vials. A form titled "Highlights of Prescribing Information - Alfuria, Influenza Vaccine" dated 4/2015, received from the Southwest Unit Manager indicated "...16.2 Storage and Handling...Once the stopper of the multi-dose vial has been pierced the vial must be discarded within	F 0431	It is the practice of this facility to ensure facility procedures are followed relating to dating of vials when opened How alleged deficient practice was corrected: Both vials were destroyed Nursing staff was in-serviced regarding facility policy on labeling and dating open vials How others were identified to have potential to be affected by alleged deficient practice: 100% audit was completed of all nursing refrigerators Open vials observed to have dates when opened as indicated by professional standards. systematic change to ensure alleged deficient practice does not recur| Visual signage will be placed on the doors of the refrigerators to remind nurses that open vials have to be dated. Nurses will audit refrigerators daily prior to the end of their shifts and will remove any vials that are found to be opened. TB and Influenza Vaccine will be moved to 1 central location for easier monitoring purposes. How system will be monitored to ensure alleged deficient practice does not recur: Unit managers will check refrigerators 3 times a week for 4 wks, then 1 time a week for 4 weeks, and then 1 time a month	03/03/2016

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	28 days...." Another form title " Medications with Special Expiration Date Requirements," dated 2007, from the facility's pharmacy indicated "...PPD [Purified Protein Derivative] (Aplisol, Tubersol) expiration date 30 days after opening...." 3.1-25(o)		for 3 months. Findings will be recorded on a audit tool which will be turned into the DON for her review. Any trends identified will be addressed by QAPI team members. Threshold of 100% compliance with open vials not marked for 3 months will be confirmation to discontinue additional monitoring. QAPI will discuss 1 time month for 6 months .	
F 0441 SS=F Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (b) Preventing Spread of Infection (1) When the Infection Control Program			

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	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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review the facility failed to ensure general infection control practices were followed related to handling of clean and soiled linens on 4 of 4 nursing units, care and suctioning of tracheostomy (Resident #169), storage of respiratory care items on 4 of 4 nursing units, storage of personal hygiene items, soiled linens on the floor, storage of patient care equipment on 4 of 4 nursing units. This deficient practice had the potential to affect 147 out of 147 residents. In addition, the facility failed to provide a sanitized water pitcher daily for 3 of 40 resident's room observed. (Resident # 24, Resident #67 and Resident #152) Findings include:	F 0441	It is the practice of this facility to maintain an Infection Control. Program designed to provide a safe, sanitary and comfortable environment This includes routine education regarding infection control with our employees Corrective action for alleged deficient practice: Infection control in-service is planned for 2-29-16 with staff to discuss proper handling of clean and soiled linen, proper suctioning of tracheostomies, proper storage of respiratory care items and personal items and distributing clean water pitchers Rm 425-O2 tubing replaced and put in plastic bag rm 502-Suction machine cleaned and put away, tubing replaced and put into plastic bag 323-brief was removed from closet and closet floor cleaned 309, 411, personal care items were put away 303	03/03/2016

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	1. During a tour of the facility on 01/26/2016 from 11:00 A.M. thru 2:00 P.M., the following was noted in resident rooms: Oxygen tubing was observed to be hanging on an oxygen machine uncovered in room 425. An uncovered suction machine was laying on the bedside table in a residents room along with oxygen tubing hanging over an oxygen tank uncovered in room #502. A soiled brief was on the closet floor in room 323. A toothbrush and toothpaste was laying on the back of the sink in the bathroom for room 309. Soiled clothes were on the closet floor in room 303. A wheelchair pad was on the floor under the toilet in resident room 208. A toothbrush and toothpaste was laying on the back of the sink in the bathroom of 411. Soiled linen was observed on the closet floor in room 512.		clothing was picked up and floor cleaned 208 wheel chair pad removed 512-soiled linen was removed from closet and floor cleaned 426 soiled linen was removed from the bathroom, soiled urinal was removed. DON was invited to resident council 2-23-15 whereas she discussed the infection control findings of this tag and requested residents to assist with keeping personal items off the back of toilets and off the floors. Currently working to get resident families to provide containers with lids to put laundry in verses leaving on the floor. How other residents were identified to have potential to be affected by alleged deficient practice 100% environmental rounds on each unit with focus on Infection control issues. Areas noted were immediately addressed. Systematic changes to ensure alleged deficient practice does not recur: Facility will formulate a Infection Control Committee that will consist of 2 members per department that are primarily line staff and are working different shifts The Infection control committee will meet 1 time a week for 30 days and will pick 1 trend each week to focus toward improvement Once the committee is established, the committee meeting will move to 1 time a month Recommendations	

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	There were two soiled/wet towels observed hanging on a pole and under the sink in bathroom for room 426. A soiled urinal was also observed lying on the floor in the bathroom in room 426. On 01/26/2016 at 11:00 A.M., a toothbrush and toothpaste were observed to be laying on the back of the sink in resident bathroom 411. On 01/28/2016 at 12:27 P.M., Resident #78's catheter tubing was dragging on the floor in the dining room. On 2/1/2016 at 10:57 A.M., the Director of Nursing provided a policy titled "Catheter Care, Indwelling Catheter," dated 12/1/2015, and indicated the policy was the one currently used by the facility. The policy indicated "...8. Empty, clean and store bedpan or measuring device properly"...." On 2/1/2016 at 10:57 A.M., the Director of Nursing provided a policy titled "Specific Medication Administration Procedures Oral Inhalation Administration," dated 5/2012, and indicated the policy was the one currently used by the facility. The policy indicated "...W. When equipment is completely		will be turned into the Infection control nurse who will bring those to QAPI meeting for additional review and improvement ideas Additional in-services with staff to discuss infection control issues Guardian angel rounds have been implemented. Audit sheets are brought to morning stand-up meeting and any concerns are addressed. How will system be monitored to ensure deficient practice does not recur: Unit managers will be doing rounds daily on their units. Problem areas will be identified and resolved . DON/ADON will make wkly rounds 2 times wk and will track trends on a audit tool, which will be addressed in QAPI meeting 1 time month. DON and ED will start wkly meetings 1 time a week to discuss infection control issues/trends and will focus on ways to enhance staff awareness to improve infection control. ED?DON will meet 1 x a wk for 4 weeks, then 1 time a month for 4 weeks or until threshold of 100% compliance is accomplished.	

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	dry, store in a plastic bag with the resident's name and the date on it...." 2. On 1/26/16 at 10:19 A.M., Resident #24's plastic water pitcher lid was observed to have a straw in the straw hole and a white crusty looking substance around the port hole. The lid top also contained flakes of white along the edges and on top of the lid. The resident indicated the staff filled the water pitcher daily but never replaced the straw or replaced the water pitcher. On 1/26/16 at 10:30 A.M., Resident #67's water pitcher lid was observed to have the white flaky substance on the lid. Resident #67 indicated the water pitcher was never removed from the room but she had asked for a new straw today and received one. Resident #67 indicated she could see the white flaky substance around the port hole and the rim of the lid. On 1/26/16 at 11:05 A.M., Resident #152's water pitcher lid was observed to have a white substance around the port hole. The resident further indicated he never received a new water pitcher or straw. During an interview, on 2/1/16 at 12:20 P.M., the Infection Control nurse			

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	indicated the water pitchers were sanitized daily and resident's received new water pitchers daily. On 2/1/16 at 11:25 P.M., observations of Resident #24, #67 and #152's water pitcher lids were conducted with the Infection Control Nurse. The nurse confirmed a white scaly substance was on the top on the water pitcher lids. Resident #67 explained to the Infection Control Nurse, she had not noticed any staff member removing her water pitcher and replacing it with a clean pitcher each day. On 2/1/16 at 12:30 P.M., the Infection Control Nurse provided a policy titled "Sanitizing Patient Water Pitchers", dated 2011, and indicated the policy was the one currently used by the facility. The policy indicated "...Patient water pitchers, cups and trays will be changed, washed and sanitized daily...." A hand written note at the bottom of the policy indicated "...*Night shift is responsible to trade out water pitchers dly [daily] with sanitized pitchers From Dietary...." 3. During an initial tour on 1/25/16 at 11:20 A.M., a dirty linen cart was observed, on the Dementia unit, sitting in the hallway. The dirty cart had clean folded linen laying on top of the cart.			

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	CNA (Certified Nursing Assistant) #3 was observed in a resident's room by the cart. CNA #3 indicated the linen (a blanket, pillow cases and fitted sheets) were clean and lying on the top of the cart's lid. CNA #3 indicated the cart was for dirty linen and trash. On 2/1/16 at 11:12 P.M., the Director of Nursing (DON) provided a policy titled, "Linens", dated 12/1/2014, and indicated the policy was the one currently used by the facility. The policy did not address the handling of clean linen only contaminated linen. 4. During an observation of tracheostomy care, conducted on 02/02/16 at 10:46 A.M., the following was noted: LPN (Licensed Practical Nurse) #33 washed her hands and obtained a towel and suctioning supplies from a closet in the resident's room. She positioned the towel across Resident #169's body and placed the tracheostomy supplies on the over bed table. LPN #33 opened the tracheostomy cleaning kit, opened the gloves, located in the kit, and placed a glove on her left hand. She then proceeded to arrange the rest of the items in the kit and realized she had to open the bottle of liquid in the kit and contaminated her gloved hand. She then put a pair of new gloves on both hands,			

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	then using both gloved hands, she removed the oxygen tubing from the resident's tracheal opening and removed the resident's old dressing from around the stoma. During the process, Resident #169 coughed and a large amount of mucous substance sprayed all over LPN #33's left, gloved hand and was noted dripping off of her gloved hand. LPN #33 continued the cleaning process without changing her gloves. The resident's inner cannula was changed without LPN #33 changing her gloves or maintaining a sterile field while touching the new cannula. During the cleaning process, LPN #34 entered the room to assist LPN #33. After the cleaning process was completed, LPN #33 and #34 were noted to discuss wether Resident #169 needed suctioning. LPN #33 then decided to suction Resident #169. LPN #33 washed her hands again, and obtained a suctioning kit, donned both sterile gloves, then with both hands gathered up the paper wrapping from the gloves and threw the paper in the trash can. She then handled the packaging and the trach suction tubing with her contaminated gloved hands. After connecting the suction machine tubing to the end of the suction catheter, LPN #33 was noted to have the suctioning catheter wrapped around her left hand. She then guided the tubing into the resident's			

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	tracheostomy opening with her right hand, applied suctioning and pulled the catheter tubing back out of the resident's tracheostomy opening. The portion of the suction catheter which had been inserted was then wrapped around her right contaminated gloved hand. In between suctioning, LPN #33 rested her right hand, which had the suction catheter wrapped around it, on the towel which had been placed across the resident's body. She repeated the process of suctioning two more times. The current policy and procedure, titled "Trach Care," undated, provided by RN (Registered Nurse)#35, on 02/02/16 at 11:20 A.M., included the following: "...Wear sterile gloves when caring for tube and stoma site..." The procedure for Tracheostomy Inner Cannula Care indicated specific instruction to donn a sterile glove on the nurse's dominant hand just before touching the inner cannula and stoma. The procedure for Tracheostomy Suctioning indicated the following: "5. Assess respiratory status. 6. Open sterile normal saline bottle 7. Open suction catheter kit. 8..Don sterile gloves. Throughout the procedure the dominant gloved hand should remain sterile and non dominant gloved hand should be kept clean 9. Open sterile container for flushing catheter and pour			

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	155685		02/02/2016

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	in sterile normal saline into sterile container with the non-dominant hand. 10. Attach the sterile catheter to suction machine tubing, holding sterile catheter in dominate hand. 11. Turn suction on to a range of 80 - 120 mm Hg [milliliters of mercury] pressure with non-dominant hand. 12. Insert the sterile catheter quick and gently until you feel resistance. Do not apply suction while inserting. 13. With your non-dominant gloved hand cover the suction control opening of the catheter and apply intermittent suctioning as you gently rotate and withdraw the catheter. 14. Do not suction more than 10 seconds at a time. 15. Assess respiratory status. 16. Dip the catheter into the sterile saline to rinse catheter until it is clear of secretions...." 3.1-18(a) 3.1-19(g)			
F 0456 SS=D Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interviews, the	F 0456	It is thepractice of this facility to maintain all essential mechanical,	03/03/2016

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	facility failed to ensure the garbage disposal in the kitchen was maintained in working order for 1 of 1 kitchen disposals. Finding includes: On 1/25/16 at 10:20 A.M., during the initial kitchen tour with the Dietary Manager, the following was observed in the dish room: located at the end of a stainless steel counter top adjacent to the dishwasher a circular opening 12 inches in diameter had a tan watery liquid with food particles floating in it. The watery solution was overflowing onto the countertop where 3 empty plastic dishwashing baskets was observed stacked on top of each other sitting in the water solution. Several plastic coffee cups, dirty ceramic plates and silverware was also observed stacked on top of each other sitting in the tan liquid that was overflowing onto the counter top. During an interview, on 1/25/16 at 10:25 A.M., the Dietary Manager indicated the circular opening in the counter top with the tan fluid coming out of it was the garbage disposal. She further indicated the garbage disposal had not worked for at least 6 weeks. When questioned as to why it was not working and what was being done to repair it the Dietary		electrical, andpatient care equipment in safe operating condition. Correctiveaction taken for alleged deficient practice: The garbagedisposal was fixed on 1/26/16 while the annual surveyors were in thebuilding. All staffhave received in-service regarding the maintenance "Building Engines Program"and have been showed how to submit and report any broken equipment as well ashow to submit work orders. Identificationof others with potential to be affected by alleged deficient practice: The ED andMaintenance Director completed unit rounds. Work orders have beensubmitted for equipment found to be non-functioning. All Dietary equipment was found to be inworking condition. Systematicchange to ensure that alleged deficient practice does not recur: MaintenanceDirector& Dietary Manager will makeweekly rounds through the kitchen to ensure that all equipment is functioning. Howcorrective action will be monitored to ensure that alleged deficient practicedoes not recur The ED willmonitor work orders Mon-Friday x's 4 wk, then 1 x wkly for 4 wks, and then 1xmonth for 3 months through building engines	

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	Manager indicated she pours bleach into the disposal daily and was unsure when the disposal would be repaired. During an interview, on 1/25/16 at 11:50 A.M., Dietary Aide #8 indicated she started working in the kitchen in October 2015 and the garbage disposal had not worked since she started her employment. During an interview, on 2/1/16 at 11:35 A.M., the Administrator indicated there was no current policy regarding maintaining kitchen equipment. She further indicated whenever anything in the building needs repaired the staff are able to fill out a work order on the computer. The maintenance department can then print the work order off and complete the work according to the immediacy of the situation. The Administrator indicated she recently ran a log for the dietary department and did not find any work orders logged in for the garbage disposal to be repaired. The Administrator further indicated she was made aware of the garbage disposal not working on 1/25/16 she then had the maintenance department fix it the next day. This federal tag relates to Complaint IN00190501.		program. A list of work orders will be kept in thesurvey binder and will be checked off when completed. ED will meet with the Maintenance directoronce a week to discuss maintenance equipment. ED will review audit results with QAPI team members 1 x month for 6 months. Discontinuation of additional monitoring willbe determined when threshold of 100% compliance with submitting work orders isreached.	

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	3.1-19(bb)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interviews, the facility failed to ensure resident rooms and equipment were maintained in a sanitary manner on 3 of 4 nursing units. Findings include: During the first two days of the survey, January 25, and 26, 2016 the following was noted in resident rooms: Room 215B - The bed linens had a brown substance on the pillow case and the fitted sheet. . Room 214B - The toilet seat, and sink in the bathroom was soiled with brown and amber colored speckles. Room 211B - The bedside dresser and radio was covered with a white substance.	F 0465	It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public Corrective action for alleged deficient practice: Rm 215B- new linen was put on bed Rm 214- toilet was cleaned Rm 211B- bedside dresser and radio were dusted Rm 202- floor tile next to the bed was replaced, bathroom floor was fixed Rm 219A- Room was deep cleaned and wall was repaired, night stand was replaced Rm 404- toilet/toilet riser were cleaned Rm 407- bedpan & urinal removed, bathroom floor was repaired Rm 413- closet doors were painted, pink tape was removed from grab bars, room wall was repaired Rm 411- bathroom wall was repaired Rm 423- bathroom floor was repaired Rm 416- over bed table was replaced, bathroom floor was repaired and toilet seat was cleaned Rm 425- flooring was fixed in the bathroom Rm 303- wall was repaired, floor was deep	03/03/2016

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	Room 202 - There was part of a floor tile missing beside the bed and there were 2 holes in the linoleum in the bathroom by the toilet. Room 219A - There was a hole in the plaster with peeling paint noted in the bathroom across from the sink. The night stand had no finish on it and the floor was very sticky. Room 404 - There was a brown substance on the toilet seat and on the toilet riser. Room 407 - A bedpan and urinal, soiled with a yellow substance were uncovered, lying on the floor of the bathroom under the sink. The bathroom flooring was worn and the particle board underneath was exposed. Room 413 - The closet doors, located in the bathroom were marred and scraped there was pink, peeling tape wrapped around the grab bar by the toilet. There was an 18 inch tall area of mudded drywall noted on the corner just inside the room door. Room 411 - There were holes in the wall by the handrail in the bathroom.		cleaned, toilet was replaced Rm 313- bathroom was deep cleaned, bathroom door was repaired, toilet replaced and room dusted to remove white substance Rm 309- room was deep cleaned and toilet was replaced Rm Rm 316- toilet was replaced and floor was stripped and waxed Rm 306- bathroom floor was deep cleaned and floor stripped and waxed, toilet was replaced Housekeeping staff were in-serviced 2/19/16 regarding proper cleaning protocols for bathrooms and resident rooms Identification of other residents with potential to be affected by alleged deficient practice: Facility rounds were conducted on remaining resident rooms, Work orders were generated for all repairs that were identified on the rounds Systematic changes to ensure that alleged deficient practice does not reoccur: The maintenance director and environmental director will tour 1 unit per week, focusing on identification of areas that need clean and/or repaired An action place will be developed to address any areas that are identified Remaining bathrooms and floors are listed on the project calendar and will be completed by the maintenance department How corrective action will be monitored to ensure alleged	

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	Room 423 - There were dark stains on the bathroom floor underneath the toilet. Room 416 - There was an over bed table with the laminate worn off the edges and the particle board exposed. The over bed table had a water pitcher on it. The bathroom floor was worn under the toilet. The toilet seat had a brown stain on the edge. Room 425 - There were holes in the bathroom flooring in front of the toilet. Room 303 - The floor in the bathroom was visibly dirty around the edges. There were holes in the wall underneath the soap dispenser in the bathroom. There was dust hanging from the sprinkler head in the bathroom. The bathroom wall was scraped about 4 inches from the floor. The toilet bowl was missing the finish and looked rusted. Room 313 - The 3 drawer dresser top was visibly dirty. The bathroom had a strong urine odor. The bathroom floor was discolored. The doorframe in the bathroom was rusted. The toilet bowl was missing some finish. Room 309A - There was a rag hanging from the toilet plumbing pipe and an open bag of briefs on the floor in the		deficient practice does not reoccur: Room round audits of 5 rooms per unit will be completed by the maintenance director and the environmental director, and will be turned in to the ED for review The ED will meet with both departments 1x/week to develop action steps for 90 days ED will discuss environmental trends with QAPI team 1x/month for 90 days then 1x quarterly thereafter until resident environmental scores reach threshold of 100%	

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	bathroom. The toilet bowl was missing some finish. Room 308B - The toilet bowl was heavily scratched. There was pink tape wrapped around the grab bar in the bathroom. There were missing handles on the top two drawers of the resident's dresser. Room 316B - The toilet bowl was missing finish. The floor was discolored in the bathroom. Room 306 - The bathroom floor was discolored. There were no paper towels in the bathroom. Room 323 - The metal baseboard heater cover straps were loose and bent. The floor around the edges of the bathroom was visibly dirty. The toilet bowl was missing finish. During the Environmental Tour of the facility, conducted on 02/01/16 from 10:15 A.M. - 11:30 A.M., accompanied by the Maintenance Supervisor and the Administrator, the same issues were noted in these rooms. During an interview with the Administrator, on 02/01/16 at 10:30 A.M., she indicated she had ordered new toilets to replace all of the toilets with missing finish. A work			

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	order and projected completion date to replace the toilets was not provided as requested. During an interview with the Maintenance Supervisor, on 02/01/16 at 11:00 A.M., he indicated the bathrooms and bathroom floors were to be remodeled and replaced, however, no schedule, work orders, or projected completion date was provided for the repairs as requested. The contracted Housekeeping service cleaning schedule for Housekeepers on all of the facility ' s nursing units, provided on 01/25/16 at 11:30 A.M., indicated resident rooms were to be cleaned daily using a 5 step and 7 step procedure. The 5 step procedure included: " Pull trash/Replace liner, Horizontal Surfaces, Vertical Surfaces, Dust Mop, Damp Mop " The 7 step procedure included: " Check/Refill supplies, Pull trash/replace liner, Dust Mop/sweep, Clean Sink area/ Tub, Clean Commode/Base, Clean Walls/Partitions, Damp mop. " 3.1-19(f)			