

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2015
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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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F 0000 Bldg. 00	<p>This survey was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 31, September 1, 2, 3, 4, 8, 9, 2015</p> <p>Facility number: 000044 Provider number: 155106 AIM number: 100274940</p> <p>Census bed type: SNF/NF: 145 Total: 145</p> <p>Census payor type: Medicare: 20 Medicaid: 96 Other: 29 Total: 145</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on 9/11/15.</p>	F 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies. This Provider is requesting a face to face IDR for F161, F371, F465 and F520 as the facility does not agree all facts were applied and should not be cited. This Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review for paper compliance in lieu of post survey visit on or after October 9, 2015</p>	
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the</p>			

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

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

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	<p>resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of blood sugar results in accordance with his orders for 1 of 1 resident reviewed for blood sugar monitoring with physician notification orders. (Resident #31)</p>	F 0157	<p>F157 - Notification: This Provider consistently ensures physicians are notified upon resident change of condition or as followed by in accordance with physician orders. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Resident</p>	10/09/2015

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	<p>Findings include:</p> <p>The clinical record for Resident #31 was reviewed on 9/2/15 at 2:40 p.m. Diagnoses for Resident #31 included, but were not limited to, diabetes, dementia with depression, malaise and fatigue.</p> <p>A health care plan problem, dated 12/10/14, indicated Resident #31 had a diagnosis of diabetes and was at risk for adverse effects of hyperglycemia or hypoglycemia. Interventions for this problem included, but were not limited to, "monitor blood sugars as ordered, document abnormal findings and notify the physician."</p> <p>A history of diabetic physician orders for Resident #31 included, but were not limited to, the following:</p> <p>a. Glucometer BID (twice a day), "if blood glucose is less than 70 or greater than 300 call the physician." This order started on 6/19/15. From 12/22/14 to 5/16/15, Resident #31 had an order for a glucometer twice a day on Fridays, "if blood glucose is less than 70 or greater than 250 call the physician." From 5/16/15 to 5/20/15, Resident #31 had an order for a glucometer twice a day, "indicate in physician binder blood glucose results higher than 200 and call</p>		<p>#31 - physician reviewed resident blood sugar for past 3 months with no changes made to plan of care. Resident is seen routinely by Endocrinologist. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</p> <p>Resident with call orders for blood glucose were reviewed and audited to ensure physician notification occurred. Audit was completed by DNS reviewing resident accucheck results for diabetic residents with blood sugar monitoring orders. Any out of range Blood sugar were reviewed for physician notification. No new orders or changes in plan of care as result of audit and findings. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Licensed nursing staff were re-educated on the this Providers blood sugar monitoring policy including physician notification. DNS and/or designee will monitor blood sugar results weekly x 4 weeks to ensure physician notification of abnormal results have occurred. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality</p>		

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	<p>the physician if blood glucose results greater than 300." From 5/21/15 to 6/19/15, Resident #31 had an order for a glucometer twice a day, "if blood glucose less than 70 or greater than 250 call the physician."</p> <p>b. Humalog (insulin) 5 units, subcutaneous, once a day with dinner was initiated on 8/8/15.</p> <p>c. Lantus (insulin) 16 units, subcutaneous, at bedtime was initiated on 8/27/15.</p> <p>d. Humalog (insulin) 13 units, subcutaneous, once a day with lunch was initiated on 8/28/15.</p> <p>e. Tradjenta (a diabetes medication) 5 milligrams (mg), once a day was initiated on 6/18/15.</p> <p>f. Amaryl (a diabetes medication) 4 mg, twice a day was initiated on 6/30/15.</p> <p>g. Glipizide (a diabetes medication) 5 mg, once a day was initiated on 8/18/15.</p> <p>The May and June 2015, Medication Administration Records (MAR) indicated the following:</p> <p>On May 23, at 4:00 p.m., the blood</p>		<p>assurance program will be put into place Diabetic monitoring CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed.</p>				

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	<p>glucose result was 256.</p> <p>On May 28, at 4:00 p.m., the blood glucose result was 251.</p> <p>On May 31, at 4:00 p.m., the blood glucose result was 272.</p> <p>On June 15, at 4:00 p.m., the blood glucose result was 269.</p> <p>On June 19, at 7:00 a.m., the blood glucose result was 304.</p> <p>The clinical record lacked any information to indicate the physician had been notified of the blood glucose results greater than the parameter orders in place at the time of the results.</p> <p>On 9/8/15, at 9:26 a.m., the Director of Nursing (DON) provided a handwritten, signed statement from LPN #22 on a plain white piece of paper. Resident #31's name was written at the top of the page and the statement indicated "On the following dates 6/2/15 and 6/11/15. In regards to the residents 4 pm Blood sugars were done and were within call parameters. I am aware that call orders were below 70 and greater than 250 at these dates. Blood sugars were done and within limits."</p>			

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F 0161 SS=B Bldg. 00	<p>Review of the current facility policy, revised on 2/2015, titled "Blood Glucose Monitoring", provided by the DON, on 9/9/15 at 9:26 a.m., included, but was not limited to the following:</p> <p>"...PROCEDURE... ...The physician will be notified when the residents's blood glucose is outside the physician stated parameters...</p> <p>3.1-5(a)(3)</p> <p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>Based on interview and record review, the facility failed to ensure the surety bond was a sufficient amount to cover the amount of money in the resident trust funds at all times. This deficient practice had the potential to affect 87 of 87 residents with Resident Funds accounts managed by the facility.</p> <p>Findings include:</p> <p>The facility's surety bond and bank statements for the resident trust accounts</p>	F 0161	<p>F161 Surety Bond - It is the consistent practice of this Provider to assure the security of all personal funds of residents deposited with the facility What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice This provider respectfully requests an IDR resulting in the deletion of this tag in that this Provider fully meets the standards allowing for complete and full security of resident funds. This Provider has</p>	10/09/2015

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	<p>were on the Conference Room table on 9/3/15 at 8:05 a.m. The statements indicated on 5/1/15, the resident trust account had a balance of \$88,282.18 in it at one point of time during that day. The surety bond was for \$80,000.</p> <p>Resident trust accounts were reviewed with the Business Office Manager on 9/8/15 at 1:48 p.m. During the review the Business Office Manager indicated she was not aware of the resident trust account balances being higher than the amount of the surety bond.</p> <p>During an interview with the Administrator on 9/9/15 at 8:20 a.m., he indicated the corporate office was responsible for reviewing the surety bond to ensure it was adequate to cover resident trust accounts.</p> <p>On 9/9/15 at 11:08 a.m., the Business Office Manager indicated the facility managed funds for 87 residents.</p> <p>3.1-6(i)</p>		<p>a surety bond in place for the sum of \$80,000 assuring the safety and security of all residents funds deposited with the facility. The facility provided information to the surveyor that the security of funds are further safeguarded in that the daily ending balance is never over \$47,000. The facility RFMS banking account works in a way that allows for all of social security checks to be deposited and is auto transferred the same day to our operating account for liabilities making our balance of \$47,000 or less at the end of each day - ensuring our surety bond of \$80,000 is well adequate for resident fund security. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents with funds in the providers resident trust account have the potential to be affected by the alleged practice. The facility RFMS banking account works in a way that allows for all of social security checks to be deposited and is auto transferred the same day to our operating account for liabilities making our balance of \$47,000 or less at the end of each day - ensuring our surety bond of \$80,000 is well adequate for resident fund security. An audit of the resident account was completed to validate that no ending balance exceeded the balance of \$47,000</p>		

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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, interview and record review, the facility failed to provide care and services in a manner to promote and/or maintain resident dignity regarding providing assistance when requested and/or when indicated, sitting	F 0241	never exceeding the surety bond limit of \$80,000 What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur The resident fund account is set to auto deduct at the end of each day to create an ending day balance of \$47,000 or less. How the correctiveaction(s) will be monitored to ensure the alleged deficient practice will notrecur, i.e., what quality assurance program will be put into place Administrative Accounting CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed. F241 Dignity - This Provider consistently promotes care for residents in a manner and environment that maintains each residents dignity. What correctiveaction(s) will be accomplished for those	10/09/2015

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	<p>for long periods of time in the same location for dining and leisure activities and focusing on a resident's ethnic or spiritual heritage during group activities for 4 of 4 residents reviewed for dignified care and services (Residents #34, #70, #37 and #94).</p> <p>Findings include:</p> <p>1. On 9/03/2015 at 9:59 a.m., a staff member asked Resident #34 if she was ready for a muffin and drink. The staff member then scooted Resident #34 up to the place at the dining table where she normally sat for meals. Resident #34 was offered a muffin. Resident #34 ate her muffin quickly. Resident #34 finished her muffin and stated "take me out of the table. Push me back to the big room." On 9/03/2015 at 10:00 a.m., Resident #34 moved herself a short distance away from the table.</p> <p>On 9/03/2015 at 10:02 a.m., Resident #34 continued to be seated a short distance from the dining table. She reached and manipulated the front wheels of her wheelchair. She attempted to move her wheelchair without success. She repeatedly reached and adjusted the wheels and tried to move her wheelchair. She moved forward or backward less than an inch and never moved forward</p>		<p>residents found to have been affected by the alleged deficient practice Resident #34 - proper assistance was provided to the resident and the IDT reviewed this resident to ensure no further issues of dignity occurred. Resident #70 - resident was and is offered preference on where she may want to sit. Resident was interviewed to determine likes and dislikes and involvement during sing along activities. Resident #37 - Proper assistance was provided to the resident and the IDT reviewed this resident to ensure no further issues of dignity occurred. Resident #94 - Proper assistance was provided to the resident and the IDT reviewed this resident to ensure no further issues of dignity occurred. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents that reside in the facility have the potential to be affected by the alleged practices Facility wide interview with each resident for dignity was completed to ensure no issues of dignity was identified. Residents unable to clearly communicate were evaluated to ensure no dignity issues were present. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Social service</p>				

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	<p>in a purposeful direction. She repeated this process over and over. Resident #34 was not offered any assistance from staff members.</p> <p>On 9/03/2015 at 10:06 a.m., Resident #34 continued to manipulate her wheelchair she remained within 8 inches of where she was originally seated at the table. Resident #34 was not offered any assistance from staff members.</p> <p>On 9/03/2015 at 10:10 a.m., Resident #34 continued to manipulate her wheels of her wheelchair and tried to move her wheelchair away from the table. She had moved back and forth about an inch at a time. Instead of making progress away from the table, she had moved backward toward the table once again. She reached down and straightened her front wheels over and over. Resident #34 was not offered any assistance by staff members.</p> <p>On 9/03/2015 at 10:12 a.m., Resident #34 continued to manipulate her wheelchair. She bent over and adjusted her front wheelchair wheels. Her movements became more jerky and she appeared agitated. She had not moved her wheelchair any farther than 8 inches from the table where she began her attempt to leave the area at 10:00 a.m. At no time during her attempt to move her</p>		<p>re-educated all staff on dignity and resident rights How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place Resident Rights CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed</p>	

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	<p>wheelchair, did staff offer Resident #34 any assistance.</p> <p>On 9/03/2015 at 10:15 a.m., Resident #34 continued to try to move her wheelchair. She bent forward and twisted and turned her front wheelchair wheels. She moved forward and back trying to move her wheelchair. The wheelchair moved up an inch then back an inch making no progress in her attempt to exit the area. The staff did not offer Resident #34 any assistance.</p> <p>On 9/03/2015 at 10:18 a.m., Resident #34 continued to try to move her wheelchair. She repeatedly reached and adjusted the front wheels. At this point the resident had almost turned herself in a small circle still within 8 inches of the table. The staff did not offer Resident #34 any assistance.</p> <p>On 9/03/2015 at 10:19 a.m.,(19 minutes after she first began to move her wheelchair without success) the Activity Assistant asked Resident #34 what she wanted then stated "Where are you going? It will be time for lunch soon. Would you like a tea? Come back to the table for that." Resident #34 stated "No, don't come back to table unless a miracle."</p>			

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	<p>On 9/03/2015 at 10:21 a.m., a staff person helped Resident #34 move from the dining area (21 minutes after she began her attempts to move her wheelchair).</p> <p>On 9/03/2015 at 10:31 a.m., Resident #34 became restless and began to call out "that is mine!"</p> <p>On 9/03/2015 at 10:32 a.m., Resident #34 yelled "help me move!" Then Resident #135, who was wandering, walked very close to Resident #34, almost brushing against her. Resident #34 began to yell loudly at the other resident saying words that could not be understood then "stand there" followed by other words that could not be understood. No staff member responded to this exchange. Resident #135 moved on from the area.</p> <p>On 9/03/2015 at 10:34 a.m., Resident #34 began talking very loud saying words such as blue and park. She then yelled "nooooo" (stretching the word out very long when spoken). Lastly she yelled "I've got to gooooooooooooo!"</p> <p>On 9/03/2015 at 10:38 a.m., Resident #34 began to talk very loudly. What she was saying was random words.</p> <p>On 9/03/2015 at 10:39 a.m., Resident #34</p>			

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	<p>began to yell "hey, hey."</p> <p>On 9/03/2015 at 10:40 a.m., (9 minutes after she began yelling, calling out and speaking loudly) the Memory Care Director spoke to her for one minute. During the time she was engaged in conversation, Resident #34 did not call out or yell. After speaking to Resident #34, the Memory Care Director did not attempt to engage the resident in any activity or provide any diversionary material.</p> <p>On 9/03/2015 at 10:43 a.m., Resident #34 began to call out loudly again "that's got a muscle."</p> <p>On 9/3/2015 at 10:44 a.m., Resident #34 was escorted by staff to the table where she sat to eat her meals (lunch was not scheduled until 12:00 p.m.). Resident #34 fell asleep in her wheelchair shortly thereafter.</p> <p>On 9/03/2015 at 11:56 a.m., Resident #34 began to move her wheelchair away from the dining table.</p> <p>On 9/03/2015 12:20 p.m., Resident #34 was escorted back to the dining table by a staff member. Resident #34 was not served her meal tray at this time.</p>			

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	<p>On 09/03/2015 at 12:22 p.m., Resident #34 left the dining table again.</p> <p>On 9/03/2015 at 12:26 p.m., Resident #34 was served her meal, escorted back to the table, and encouraged to eat.</p> <p>Resident #34's clinical record was reviewed on 9/08/2015 at 2:29 p.m. Resident #34's current diagnoses included, but were not limited to, muscle weakness, dementia, anxiety and debility. Resident #34 resided on the secured Memory Care 2 dementia care unit.</p> <p>Resident #34 had a current, 5/28/15, annual, Minimum Data Set assessment (MDS) which indicated the resident was severely cognitively impaired, rarely or never made decisions, required a mobility device and staff assistance for mobility.</p> <p>Resident #34 had a current, 5/28/15, care plan problem/need regarding hearing loss. Approaches to this problem included, but were not limited to, "place in front of room during group activities."</p> <p>Resident #34 had a current, 5/28/15, care plan problem/need regarding the need for assistance with activities of daily living.</p> <p>2. On 9/03/2015 at 12:38 p.m., Resident #94 was assisted to stand from the</p>			

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	<p>reclining chair by 2 staff members who used a gait belt to assist her. Resident #94 required assistance to rise from the chair and maintain a steady balance before walking.</p> <p>On 9/04/2015 at 8:50 a.m., Resident #94 called out "take me home." At this time, Resident #94 was seated in a dining room chair facing the dining table. The breakfast meal had already been eaten and the dishes cleared.</p> <p>On 9/04/2015 at 8:53 a.m., Resident #94 called out, "I want to go home to my bed." Resident #94 was still seated at the dining table.</p> <p>On 9/04/2015 at 8:55 a.m., Resident #94 called out "help me." Resident #94 was seated at the dining table.</p> <p>On 9/04/2015 at 8:55 a.m., a staff member placed a puzzle on the table in front of Resident #94. They did not ask her what she needed or offer her assistance.</p> <p>On 9/4/2015 at 8:57 a.m., a staff member responded to Resident #94's call for help by pulling her chair away from the table and facing Resident #94 away from the table. The staff member did not assist Resident #94 to another location or help</p>			

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	<p>her stand or obtain assistance to help her stand. Resident #94 was left seated in a dining room chair facing away from the table.</p> <p>On 9/4/15 at 8:58 a.m., Resident #94 called out. The Memory Care Director spoke to the resident. She did not obtain assistance for Resident #94 to stand or move to another location.</p> <p>On 9/04/2015 at 8:59 a.m., Resident #94 called out "Get me back to my family! Help me!" Resident #94 continued to be seated in a dining chair with her back to the table.</p> <p>On 9/04/2015 at 9:02 a.m., Resident #94 called "Help me!" An unidentified staff member indicated she would help Resident #94 in a minute. Resident #94 was seated in a dining room chair with her back to the table.</p> <p>On 09/04/2015 at 9:04 a.m., Resident #94 called out "help me." The staff member had not returned to help the resident. Resident #94 was still seated in a dining room chair with her back to the table.</p> <p>On 09/04/2015 at 9:06 a.m., Resident #94 was seated at a dining room table with her back to the table. She had never been</p>			

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	<p>assisted to stand or move to another location since her first request to "go home" at 8:50 a.m.(a period of 16 minutes). She was asleep her chin rested on her chest and she was leaning to one side.</p> <p>On 09/04/2015 at 9:08 a.m., Resident #135 walked by Resident #94. She was very close to Resident #94. Resident #94 reached out and tried to take hold of Resident #135. No staff member responded to this event.</p> <p>On 9/04/2015 at 9:09 a.m., Resident #94 cried out in a high pitched voice "Help me, O Lordy, I can't get turned around. Help! Help! " Resident #94 was seated in a dining room chair with her back to the table in the same location she had been since her chair had been turned at 8:57 a.m. (a period of 12 minutes.) At no time, since her first request to "go home" at 8:50 a.m. (19 minutes prior), had Resident #94 been assisted to stand or move to another location.</p> <p>On 9/04/2015 at 9:10 a.m., the Medical Records Nurse responded to Resident #94's cry for help by turning the resident's chair around and pushing her back to the table.</p> <p>On 9/04/2015 at 9:13 a.m., Resident #94</p>			

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	<p>pushed at the table at cried out "Help me!"</p> <p>On 9/04/2015 at 9:14 a.m., Resident #94 cried out "I want my family!" Resident #94 was seated facing the dining room table. At no time, since her first cry to "go home" at 8:50 a.m. (24 minutes prior), was Resident #94 offered assistance to stand or move to another location.</p> <p>Resident #94's clinical record was reviewed on 09/08/2015 at 12:30 p.m. Resident #94's current diagnoses included, but were not limited to, dementia, depression and chronic pain. Resident #94 resided on the secured Memory Care 2 dementia care unit.</p> <p>Resident #94 had a current, 6/4/15, quarterly, Minimum Data Set assessment (MDS) which indicated the resident had moderate hearing impairment and needed the speaker to increase his volume, was severely cognitively impaired, rarely or never made decisions, needed extensive assistance for transferring and limited assistance for both walking and locomotion.</p> <p>Resident #94 had a current, 6/4/15, care plan problem/need regarding cognitive loss and dementia. Approaches to this</p>			

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	<p>problem included, but were not limited to,"encourage resident to respond verbally/non-verbally by using gestures, cues to interact."</p> <p>Resident #94 had a current, 6/4/15, care plan problem/need regarding chronic pain. Approaches to this problem included, but were not limited to, "observe for non verbal signs of pain: changes in breathing, vocalization...."</p> <p>Resident #94 had a current, 6/4/15, care plan problem/need regarding an alteration in mobility due to dementia. Approaches to this problem included, but were not limited to,"... continues to need varied assistance with bed mobility and transfers."</p> <p>3. On 9/01/2015 at 10:43 a.m., Resident #70 was seated in the activity/dining area at the over the bed table in the same location where she consumed all of her meals. She had a magazine and a snack.</p> <p>On 9/03/2015 at 9:41 a.m., Resident #70 was seated in the activity/dining area at the over the bed table in the same location where she consumed all of her meals. She had a magazine.</p> <p>On 9/3/15 at 9:49 a.m., Resident #70 was in her wheelchair seated at an over</p>			

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	<p>the bed table in the dining/activity room at the same location where she ate her meals. She had a magazine and a hot beverage in a cup.</p> <p>On 9/3/15, Resident #70 sat at the over the bed table sometime looking at a magazine or drinking her beverage and other times doing nothing from 9:41 a.m., to 9:58 a.m. She was served a muffin at 9:58 a.m. She began to eat the muffin right away.</p> <p>On 9/03/2015 at 10:00 a.m., Resident #70 accidentally dropped her muffin to the floor. She made several attempts to reach for the muffin, but could not reach it. She stopped reaching for the muffin and sat at the over the bed table.</p> <p>On 9/3/15 at 10:04 a.m., Activity Assistant #1 began to read "The Chronicle" as an activity event. During this activity Resident #70 sat at the over bed table. Resident #70 sat facing the over the bed table where she sat to dine from 9:49 a.m. to 10:13 a.m. She was never asked if she would like to sit in any other location. Staff never offered her another muffin and her muffin was beside her on the floor.</p> <p>On 9/03/2015 at 10:13 a.m., Resident #37 walked over to the over the bed table</p>			

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	<p>where Resident #70 was seated. Resident #37 attempt to roll Resident #70's table away from her. Resident #70 had a cup and magazine on the table. Resident #70 held tightly to the table as Resident #37 pulled on it. Resident #37 let go of the table and began to touch Resident #70's items on the table and then began to touch on Resident #70. She touched on Resident #70's neck and chest. Resident #70 call out for her to stop and yelled, "no". Speech Therapist #1 (ST #1) intervened in the conflict and led Resident #37 away from the area. At this time, ST #1 did not approach a nurse and report the altercation. ST #1 then picked up the muffin from the floor. No replacement for the lost snack was offered.</p> <p>On 9/03/2015 at 10:16 a.m., Resident #70 sat rubbing her table.</p> <p>On 9/03/2015 at 10:20 a.m., Resident #70 took off her clothing protector and placed it on the table.</p> <p>On 9/03/15 at 10:27 a.m., Resident #70 tried to push her wheelchair away from the over the bed table.</p> <p>On 9/03/2015 at 10:30 a.m., Resident #70 was asked if she needed something and was taken to the bathroom.</p>			

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	<p>On 9/03/2015 at 10:38 a.m., Resident #70 was escorted in her wheelchair to the dining/activity room. Resident #70 was returned to the exact location where she had eaten her meal and sat during the morning activities. The staff member did not ask Resident #70 where she liked to sit and simply returned her to her routine location.</p> <p>On 9/03/2015 at 10:40 a.m., Resident #70 attempted to move her wheelchair backwards and was unsuccessful. A singing activity was offered at this time and the resident continued to be seated in the same location.</p> <p>On 9/03/2015 at 10:43 a.m., Resident #70 sat facing her over the bed table in her standard dining location. She manipulated the clothing protector that was on the over the bed table.</p> <p>On 9/03/2015 at 10:44 a.m., Resident #70 called out.</p> <p>On 9/03/2015 at 11:45 a.m., Resident #70 was escorted by a staff member back into the dining room after she had been to the restroom. Resident #70 indicated she did not want to sit in the same location. The staff member talked persuasively to Resident #70 and got her to agree to go</p>			

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	<p>back to the same over the bed table where she sat all morning.</p> <p>On 9/3/15 at 11:46 a.m., a singing activity was in progress. The activity included singing old time favorite songs. The activity did not include songs that represented the resident's faith or heritage.</p> <p>On 9/03/2015 at 11:50 a.m., Activity Assistant #2 (AA #2) asked Resident #70 if she would like to sing one of her "Jewish songs" to everyone. Resident #70 indicated she did not desire to do so.</p> <p>On 9/03/2015 at 12:01 p.m., AA#2 again asked Resident #70 if she would like to sing them "one of her Jewish songs." Again Resident #70 indicated no.</p> <p>On 9/03/2015 at 12:13 p.m., AA#2 asked Resident #70 if she knew any "Jewish songs" she could sing for everyone. Again Resident #70 refused. At no time during the singing event did AA#2 ask any other Residents if they would like to sing songs about their faith or heritage. She singled Resident #70 out on three occasions and asked her to sing songs from her faith.</p> <p>On 9/03/2015 at 2:34 p.m., Resident #70 was seated in the activity/dining room at</p>			

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	<p>the over the bed table where she ate her meals. Resident #70 was not eating at this time. She sat facing her table doing nothing from 2:34 p.m. until 2:49 p.m. when she was offered ice cream. After eating her ice cream, Resident #70 sat at her table with a closed magazine and glass of water until 2:51 p.m. At 2:54 p.m. Resident #70 attempted to push her wheelchair away from the table and was only able to move it a few inches. At 2:56 p.m., nursing staff responded and offered the resident toileting assistance.</p> <p>On 9/04/2015 at 8:47 a.m., Resident #70 sat in her wheelchair at an over the bed table with a drink and a magazine on the table. This was the same location where she sat for all activities and events the day before and where she ate her meals. At 8:50 a.m., Resident #70 was taken to the restroom. At 8:56 a.m., Resident #70 was escorted back from the bathroom and placed at the same over the bed table. Resident #70 was not asked where she would like to sit nor did she freely make a statement that she would like to sit in the same seat she had been at to eat her meals. Resident #70 sat at the table and periodically looked at a magazine. At 9:07 a.m., a staff member cleaned off the table top and appeared to move Residents #70's drink out of reach.</p>			

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	<p>On 9/04/2015 from 9:27 a.m. to 9:43 a.m., Resident #70 sat in the same location facing the over the bed table. A trivia event was offered during this time.</p> <p>Resident #70's clinical record was reviewed on 9/3/15 at 11:02 a.m. Resident #70 current diagnoses included, but were not limited to, dementia with behavioral disturbances and depression. Resident #70 was admitted to the facility in June 2015 and resided on the secured Memory Care 2 dementia care unit. Resident #70 lacked any indication that she desired to share her faith and heritage with others through song or any other means. Resident #70's record lacked any indication that she desired to sit in the same location on a regular basis.</p> <p>Resident #70 had a current, 6/11/15, admission, Minimum Data Set assessment (MDS) which indicated the resident was severely cognitively impaired, rarely or never made decisions, required staff assistance for mobility and transferring.</p> <p>Resident #70 had a current, 6/8/15, care plan problem/need regarding behavioral problems. Approaches to this problem included, but were not limited to, "assess for unmet needs."</p>			

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	<p>4. On 9/3/2015 at 2:34 p.m., Resident #37 was hand-held assisted by staff to walk to and sit in a recliner.</p> <p>On 9/03/2015 at 2:41 p.m., Resident #37 was seated in the recliner. She began to move restlessly and call out. She raised her body as if attempting to stand and then lowered herself to the recliner.</p> <p>On 9/03/2015 at 2:45 p.m., Resident #37 began to move restlessly and quickly rub the arms of the recliner. She called out as she moved about.</p> <p>On 9/03/2015 at 2:48 p.m., Resident #37 yelled "please help, please help!" An unidentified CNA, who was wearing the facility assigned red uniform, stated she would "be right back." This is the first time a staff member spoke to Resident #37 since she began calling out at 2:41 p.m. (a period of 7 minutes).</p> <p>On 9/03/2015 at 2:50 p.m., Resident #37 was still seated in the recliner and had never been offered any assistance. Resident #37 called out "hurry it up bed time."</p> <p>On 9/3/15 at 2:52 p.m., Resident #37 was offered assistance to stand (a period of 11 minutes since she first asked for help).</p>			

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	<p>On 9/04/2015 at 8:46 a.m., Resident #37 was seated in the dining/activity room. She called out "somebody help me." There was no staff response.</p> <p>On 9/04/2015 at 8:49 a.m., Resident #37 continued to periodically call out and yelled "come here."</p> <p>On 9/04/2015 at 8:53 a.m., a staff member responded to Resident #37 for the first time she had asked for assistance at 8:46 a.m. and asked Resident #37 what she wanted. Resident #37 was then assisted to stand and she began to walk (a period of 7 minute waiting for staff response).</p> <p>On 9/4/15 at 9:05 a.m., Resident #37 was once again seated in the recliner calling out. Resident #37 sat in the recliner and called out periodically from 9:05 a.m. to 9:14 a.m. At 9:14 a.m., She called out "Help, Help!" There was no staff response.</p> <p>On 9/04/2015 at 9:16 a.m., Resident #37 sat in the recliner and called out "help, help!"</p> <p>On 9/04/2015 at 9:19 a.m., Resident #37 was still seated in the recliner calling out (a period of 14 minutes since she began to cry out). At this time, no assistance</p>			

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	<p>had been offered to the resident.</p> <p>Resident #37's clinical record was reviewed on 9/08/2015 at 1:40 p.m. Resident #37's current diagnoses included, but were not limited to, depression, dementia, Alzheimer's disease and anxiety.</p> <p>Resident #37 had a current, 7/23/15, significant change, Minimum Data Set assessment (MDS) which indicated the resident had unclear speech, rarely understood others or was rarely understood by others, required cueing and assistance for decision making and required staff assistance for transferring.</p> <p>Resident #37 had a current, 7/23/15, care plan problem/need regarding cognitive loss and dementia. Approaches to this problem included, but were not limited to, "offer assistance and encouragement as needed..."</p> <p>Resident #37 had a current, 7/23/15, care plan problem/need regarding needing assistance with activities of daily living.</p> <p>Resident #37 had a current, 7/23/15, care plan problem/need regarding behavioral symptoms such as pacing or exit seeking. Approaches to this problem included, but were not limited to, "Redirect with</p>			

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	<p>snacks/fluids, distract resident with activities such as wiping tables, and offer resident opportunities to socialize and engage in meaningful activities."</p> <p>5. On 9/04/2015 at 9:43 a.m., the tables were moved back and over in the Memory Care 2 dining room. Residents were placed in a circle to play ball using a large beach ball. This was the first activity that was observed on 8/31/15, 9/1/15, 9/3/15 and 9/4/15 where residents did not participate in the activity while seated in the same location where they ate their meals. Residents participated in the activity, laughed, sang and spoke from time to time. "Malt shop" music was played during this event. Residents responded in a positive manner. Resident #70 was seated in the circle away from her dining room seat and laughed and participated in the activity. Resident #34 also laughed and participated in the activity. Resident #94 joined in the activity as well. Resident #135 was persuaded to sit beside CNA #6 and sat and participated in the activity with encouragement. Resident #37 also participated in the activity.</p> <p>During a 9/08/2015 at 1:52 p.m. interview, LPN #18 who was working on the Memory Care 2 Unit indicated residents did not have seating</p>			

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F 0309 SS=D Bldg. 00	<p>assignments but residents did sit in their customary seats.</p> <p>During a 9/8/15, 12:41 p.m., interview, The Memory Care Director indicated activity/dining space was an issue in the Memory Care unit so the facility used the dining area for activities. She additionally indicated routine was good for the residents. She answered yes, the furniture in the activity/dining area could be moved around and was not stationary.</p> <p>3.1-3(t)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to provide interventions for residents who had dementia and displayed behaviors for 2 of 3 residents reviewed for behavior management. (Resident #135 and #37) These behaviors also impacted Resident #70 and #34.</p>	F 0309	F309 Provide Care Highest Well being - This Provider consistently provides interventions for residents with dementia displaying behaviors What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Resident	10/09/2015			

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	<p>Findings include:</p> <p>1. On 9/03/2015 at 9:49 a.m., Resident #135 wandered out of the activity/dining area and down the hall with resident rooms.</p> <p>On 9/03/2015 at 9:56 a.m., Resident #135 was wandering up and down the hall then in and around the dining/activity room.</p> <p>On 9/03/2015 at 10:17 a.m., Resident #135 was wandering throughout the unit manipulating the hem of her top.</p> <p>On 9/03/2015 at 10:22 a.m., Resident #135 was wandering throughout the unit up and down the hallway and through the activity/dining room.</p> <p>On 9/03/2015 at 10:32 a.m., Resident #135, who was wandering, walked very close to Resident #34 almost brushing against her. Resident #34 began to yell loudly at the other resident saying words that could not be understood then "stand there" followed by other words that could not be understood. No staff member responded to this exchange. Resident #135 moved on from the area.</p> <p>On 9/03/2015 at 10:36 a.m., Resident #135 was wandering up and down the hall then in and around the dining/activity</p>		<p>#135 - Resident Careplans were reviewed and updated to reflect current interventions for resident needs. Reviewed proper interventions with staff to ensure meeting each residents needs. Resident #37 - Resident careplans were reviewed and updated as needed to reflect current and accurate interventions for resident needs. Reviewed proper interventions with staff to ensure meeting each resident needs. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents with dementia displaying behaviors have the potential to be affected by the same alleged practice. Residents with dementia/behaviors careplans were reviewed and updated as needed to reflect current and accurate intervention for their resident specific behaviors. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Staff were inserviced on resident rights and resident specific interventions on each resident individual needs based on their specific needs and responses. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e.,</p>	

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	<p>room.</p> <p>On 9/03/2015 at 10:41 a.m., Resident #135 was wandering up and down the hall then in and around the dining/activity room.</p> <p>On 9/03/2015 at 12:15 p.m., Resident #135 sat with her family and ate her lunch. She was able to stay in the seat and not wander when provided with conversation, personal contact and encouragement.</p> <p>On 9/03/2015 at 2:36 p.m., Resident #135 wandered the hallway entering and exiting resident rooms. She entered rooms 105, room 113, and room 114 which were not her room.</p> <p>On 9/04/2015 at 8:47 a.m., Resident #135 was wandering throughout the unit up and down the hallway and through the activity/dining room.</p> <p>On 9/04/2015 at 8:52 a.m., Resident #135 was wandering throughout the unit up and down the hallway and through the activity/dining room.</p> <p>On 9/04/2015 at 9:06 a.m., Resident #135 was wandering throughout the unit up and down the hallway and through the activity/dining room.</p>		<p>what quality assurance program will be put into place Behavior management CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed</p>	

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	<p>On 09/04/2015 at 9:08 a.m., Resident #135 walked by Resident #94. She was very close to Resident #94. Resident #94 reached out and tried to take hold of Resident #135. No staff member responded to this event.</p> <p>On 9/04/2015 at 9:14 a.m., Resident #135 was wandering throughout the unit up and down the hallway and through the activity/dining room.</p> <p>On 9/4/2015 at 9:39 a.m., Resident #135 was wandering throughout the unit up and down the hallway. She wandered into room 113, which was not her room.</p> <p>During the time Resident #135 wandered on 9/3/2015 and 9/4/2015 until 9:43 a.m., staff members did not try to engage her in a safe activity. They did not offer her sensory devices or offer individual conversation. They simply redirected her from the hallway back into the activity/dining area where she walked about and quickly left the area. When encouraged she was able to stop ambulating and sit with her family for a meal on 9/3/15 and join an activity group on 9/4/15 at 9:43 a.m.</p> <p>Resident #135's clinical record was reviewed on 9/8//2015 at 1:24 p.m.</p>			

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	<p>Resident #135's current diagnoses included, but were not limited to, dementia with delusions, depression and chronic pain.</p> <p>Resident #135 had a current, 6/1/15, quarterly, Minimum Data Set assessment (MDS) which indicated the resident had unclear speech, was rarely or never understood, rarely or never understood others, she was severely cognitively impaired and rarely or never made decisions.</p> <p>Resident #135 had a current, 6/1/15, care plan problem/need regarding wandering putting her at risk. Approaches to this problem included, but were not limited to, "encourage resident to be in common area as much as possible, redirect resident when noted to be in an undesirable location."</p> <p>Resident #135 had a current, 6/1/15, care plan problem/need regarding behavioral symptoms. Approaches to this problem included, but were not limited to, "assess for unmet needs and offer 1:1 time (one to one time)..."</p> <p>Resident #135 had a current, 6/1/15, care plan problem/need regarding risk for elopement due to wandering. Approaches to this problem included, but</p>			

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	<p>were not limited to, "redirect to activities of interest such as singing...dancing...and group activities."</p> <p>2. On 9/03/2015 at 10:13 a.m., Resident #37 wandered through the dining/activity room. She walked very close to residents and touched objects and people. Resident #34 walked over to the over the bed table where #70 was seated. Resident #37 attempted to roll Resident #70's table away from her. Resident #70 had a cup and magazine on the table. Resident #70 held tightly to the table as Resident #37 pulled on it. Resident #37 let go of the table and began to touch Resident #70's items on the table and then began to touch on Resident #70. She touched on Resident #70's neck and chest. Resident #70 called out for her to stop and yelled no. Speech Therapist #1 (ST #1) intervened in the conflict and led Resident #37 away from the area. At this time, ST #1 did not approach a nurse and report the altercation.</p> <p>On 09/03/2015 at 10:14 a.m., Resident #37 wandered back into the dining/activity area. She once again touched objects and people.</p> <p>On 9/03/2015 at 10:22 a.m., Resident #37 was standing at a table where other residents were seated. She rubbed the</p>			

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	<p>table and attempted to touch items on the table. Activity Assistant #2 (AA #2) attempted to escort Resident #37 away from the table, but the resident wouldn't walk with her. At this time, AA#2 did not approach a nurse or member of nursing staff for assistance.</p> <p>On 9/03/2015 at 10:36 a.m., Resident #37 was still standing and rubbing the table. The residents at the table did not appear distressed by her actions.</p> <p>On 9/3/2015 at 10:39 a.m., Resident #37 left the activity/dining room and wandered down the hall where residents' rooms were located.</p> <p>On 9/03/2015 at 10:41 a.m., Resident #37 was escorted back into the dining room by a nursing staff member. She was not given any diversionary materials at this time.</p> <p>On 9/03/2015 at 10:42 a.m., a nursing staff member tried to get Resident #37 to sit down without success. Resident #37 began to roam the room, touching people and items.</p> <p>On 09/03/2015 at 10:44 a.m., a staff member escorted Resident #37 from the area and helped her sit in a recliner.</p>			

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	<p>On 9/03/2015 at 11:46 a.m., Resident #37 was seated in a recliner calling out. She called out on and off until assisted to the dining room table at 11:52 a.m.. After being seated at the table she began to talk and call out. She stood and exited the area soon after.</p> <p>On 9/03/2015 at 11:59 a.m., Resident #37 was escorted into the dining area again and assisted to sit at the dining table.</p> <p>On 09/03/2015 at 12:01 p.m., Resident #37 was once again up walking and touching people and items. She walked behind Resident #70, whom she had touched early, Resident #70 flinched as Resident #37 walked behind her. She held tightly to the item on her table and turned her head to watch Resident #37.</p> <p>On 9/03/2015 from 12:03 p.m. to 12:07 p.m., the Medical Record Nurse held Resident #37's hand and walked with her around the unit. While walking with staff, Resident #37 did not touch others.</p> <p>On 9/3/2015 at 12:10 p.m., Resident #37 sat at the table to eat lunch.</p> <p>On 9/3/2015 at 2:34 p.m., Resident #37 was hand-held assisted by staff to walk and sit in the recliner.</p>			

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	<p>On 9/03/2015 at 2:41 p.m., Resident #37 was seated in the recliner. She began to move restlessly and called out. She raised her body as if attempting to stand and then lowered herself to the recliner.</p> <p>On 9/03/2015 at 2:45 p.m., Resident #37 began to move restlessly and quickly rub the arms of the recliner. She called out as she moved about.</p> <p>On 9/03/2015 at 2:48 p.m., Resident #37 yelled "please help, please help!" An unidentified CNA, who was wearing the facility assigned red uniform, stated she would "be right back." This is the first time a staff member spoke to Resident #37 since she began calling out at 2:41 p.m. (a period of 7 minutes).</p> <p>On 9/03/2015 at 2:50 p.m., Resident #37 was still seated in the recliner and had never been offered any assistance. Resident #37 called out "hurry it up bed time." On 9/3/15 at 2:52 p.m., Resident #37 was offered assistance to stand (a period of 11 minutes since she first asked for help).</p> <p>On 9/04/2015 at 8:46 a.m., Resident #37 was seated in the dining/activity room. She called out "somebody help me." There was no staff response.</p>			

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	<p>On 9/04/2015 at 8:49 a.m., Resident #37 continued to periodically call out and yelled "come here."</p> <p>On 9/04/2015 at 8:53 a.m., a staff member responded to Resident #37 for the first time since she had asked for assistance at 8:46 a.m. and asked Resident #37 what she wanted. Resident #37 was then assisted to stand and she began to walk (a period of 7 minutes waiting for staff response).</p> <p>On 9/4/15 at 9:05 a.m., Resident #37 was once again seated in the recliner calling out. Resident #37 sat in the recliner and called out periodically from 9:05 a.m. to 9:14 a.m. At 9:14 a.m., She called out "help, help!" There was no staff response.</p> <p>On 9/04/2015 at 9:16 a.m., Resident #37 sat in the recliner and called out "help, help!"</p> <p>On 9/04/2015 at 9:19 a.m., Resident #37 was still seated in the recliner calling out (a period of 14 minutes since she began to cry out). At this time, no assistance had been offered to the resident.</p> <p>Resident #37's clinical record was reviewed on 9/08/2015 at 1:40 p.m. Resident #37's current diagnoses</p>			

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	<p>included, but were not limited to, depression, dementia, Alzheimer's disease and anxiety.</p> <p>Resident #37 had a current, 7/23/15, significant change, Minimum Data Set assessment (MDS) which indicated the resident had unclear speech, rarely understood others or was rarely understood by others, required cueing and assistance for decision making and required staff assistance for transferring.</p> <p>Resident #37 had a current, 7/23/15, care plan problem/need regarding cognitive loss and dementia. Approaches to this problem included, but were not limited to, "offer assistance and encouragement as needed...."</p> <p>Resident #37 had a current, 7/23/15, care plan problem/need regarding needing assistance with activities of daily living.</p> <p>Resident #37 had a current, 7/23/15, care plan problem/need regarding behavioral symptoms such as pacing or exit seeking. Approaches to this problem included, but were not limited to, "Redirect with snacks/fluids, distract resident with activities such as wiping tables, and offer resident opportunities to socialize and engage in meaningful activities."</p>			

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	<p>3. During an interview on 9/08/2015 at 8:46 a.m., CNA #21 indicated she could use the computer to find how to address resident behaviors. She also indicated the nurse would offer assistance.</p> <p>During an interview on 9/08/2015 at 8:48 a.m., CNA #20 indicated she could check the computer kiosk for resident specific approaches to behavior. She indicated she would also tell a nurse about resident behaviors.</p> <p>During an interview on 9/08/2015 at 8:50 a.m., CNA #6 indicated she could use the computer to find how to manage a resident's behaviors. She indicated she would also tell a nurse.</p> <p>During an interview on 9/08/2015 at 8:52 a.m., LPN #18 indicated staff could find information about managing behaviors on the computer. She also indicated staff should report resident behaviors to a nurse so the nurse could document the behaviors.</p> <p>During an interview on 9/08/2015 at 8:59 a.m., the Memory Unit Director indicated direct care staff could use the computer kiosk to find approaches to resident behaviors. She additionally indicated the approaches mirror the approaches on the care plan. She also indicated she had not</p>			

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F 0315 SS=D Bldg. 00	<p>been informed Resident #37 had displayed intrusive touching with Resident #70 on 9/3/2015 and the event had not been documented.</p> <p>3.1-37(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to identify and assess a resident with a decline in bladder function to provide or maintain as high as normal possible urinary bladder function for 1 of 3 residents reviewed for urinary incontinence. (Resident # 149)</p> <p>Findings include:</p> <p>Resident #149 was observed on the following dates and times:</p>	F 0315	F315 Catheter - It is the consistent practice of this Provider to identify and assess residents bladder functions and address as appropriate What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Resident #149 - a 3 day voiding pattern was initiated and proper toileting program implemented based on resident need and outcomes. Careplan and profile were updated for this resident. How	10/09/2015

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	<p>9/2/15 at 2:46 p.m., in bed with her eyes closed.</p> <p>9/3/15 at 9:41 a.m., in a wheelchair by the nurse's desk.</p> <p>9/8/15 at 9:26 a.m., in bed talking to a visitor.</p> <p>9/9/15 at 11:03 a.m., in bed with her eyes closed.</p> <p>Resident #149's clinical record was reviewed on 9/4/15 at 9:38 a.m. The resident's diagnoses included, but were not limited to, urinary tract infection, depression, insomnia, constipation, pain, and atrial fibrillation.</p> <p>The resident had an, 4/10/15, admission Minimum Data Set Assessment. The assessment indicated the resident had moderate cognitive impairment, required the extensive assistance of two for transferring, the extensive assist of one for toileting and was incontinent 7 or more times during the assessment period. The assessment indicated the resident was not on a toileting program.</p> <p>The resident had a, 7/2/15, quarterly Minimum Data Assessment [MDS]. The assessment indicated the resident had moderate cognitive impairment, usually understood and could usually be understood, and required the extensive assistance of two for transferring and</p>		<p>will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</p> <p>All residents with a change in bladder function have the potential to be affected by the alleged practice Audit of residents completed - any bladder function change identified were addressed based on patient needs and outcomes. Careplans and resident profiles updated as necessary. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Re-educated nursing staff on this Providers bladder program policy and procedures. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place Bladder Program CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed.</p>		

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	<p>toileting. The assessment indicated the resident was always incontinent of urine and was not on a toileting program.</p> <p>The resident had a, 4/16/15, "Bladder Continence Review". The review indicated the resident had seven or more times of incontinence, but was continent of urine at least once during the assessment period. The review indicated the resident did not have an identified voiding pattern and was placed on a scheduled toileting program as follows: toilet upon rising, before and after meals and at bedtime. The review indicated the resident was not mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan and was not able to resist voiding to attempt a bladder retraining program.</p> <p>Resident #149 had a 4/27/15, care plan problem of "Alterations with toileting. Does not communicate toileting needs. Continency and toileting ability expected to vary." The resident had a 4/27/15, approach to this problem of "Adult briefs worn and changed as needed, along with giving of pericare." On 7/2/15, an additional approach of check every two hours for incontinence was added.</p> <p>The resident had a care plan problem relating to being at risk for skin</p>			

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	<p>breakdown and had a, 4/3/15, approach of "Adult briefs worn and changed as needed, along with pericare." An approach of "Assist with toileting" was added on 6/16/15.</p> <p>The resident had a, 4/27/15, care plan problem related to being a fall risk and had a 6/11/15, approach of "Assist resident with toileting incontinence care as needed." The resident care plan did not indicate the resident was placed on a toileting schedule.</p> <p>The "Resident Profile" indicated the following care plan approaches related to incontinence: 4/3/15, Adult briefs worn and changed as needed, along with pericare. 4/27/15, Adult briefs worn and changed as needed, along with giving of pericare. 7/2/15, Check every two hours for incontinence. The profile lacked an indication of the resident being placed on a toileting schedule.</p> <p>During an interview with CNA #3 on 9/3/15 at 9:41 a.m., she indicated the resident was able to express the need to go to the bathroom and the resident required a little assistance.</p> <p>During an interview with MDS Nurse #4,</p>			

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	<p>on 9/4/15 at 10:40 a.m., she indicated bladder assessments were completed on admission and included a three day voiding pattern. She indicated the bladder assessments are completed on admission or if the resident has a significant change triggering a new MDS assessment.</p> <p>During an interview with CNA #3 on 9/8/15 at 9:30 a.m., she indicated Resident #149 was always incontinent of urine in the morning when she went in to get the resident up. She indicated the resident would have told her when she had to go to the bathroom and it was rare for her to be incontinent during the day.</p> <p>During an interview with the Director of Nursing on 9/8/15 at 10:02 a.m., she indicated a decline in incontinence from frequently incontinent to always incontinent would not be a reason to for a bladder assessment to be completed. She indicated the CNA's used the "Resident Profile" to know what care to provide to each resident. She indicated the resident was not on a toileting program.</p> <p>The November, 2014, "Bladder Program" policy was provided by the Director of Nursing on 9/8/15 at 9:56 a.m. The policy indicated it was to "...promote independence and dignity with an</p>			

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F 0323 SS=E Bldg. 00	<p>appropriate bladder program based on each resident's ability....2. A new 3-day voiding pattern will only be completed if there is a change in level of continence....If a voiding pattern can be determined, develop an individualized resident specific program, update the care plan and resident care records/assignment sheets. If a voiding pattern cannot be determined, resident should be toileted upon rising, before or after meals, and at bedtime...."</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on interview and record review, the facility failed to ensure laboratory and urine tests were obtained as part of a post fall root cause analysis for 1 of 6 residents reviewed for accidents (Resident #164), and failed to ensure fall interventions were in place in accordance with their plan of care for 3 of 6 residents reviewed for accidents.</p>	F 0323	F323 Accident hazards - It is the consistent practice of this Provider to ensure the environment remains free of accident hazards; and that residents receive adequate supervision and devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been	10/02/2015

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	<p>(Resident #60, #193, and #9)</p> <p>B. Based on observation and interview, the facility failed to ensure the hand rails were free from sharp areas for 3 of 9 hall ways, and the bathroom call lights were at a safe distance for access from the commode for 9 out of 11 rooms observed. (J Hall, entrance hall, 100 hall, Room 224, 225, 228, 232, 235, 237, 239, 245, 248, and the Shower room)</p> <p>Findings include:</p> <p>A 1. The clinical record for Resident #164 was reviewed on 9/4/15 at 7:35 a.m. Diagnoses for Resident #164 included, but were not limited to, dementia, hypertension, and diabetes. Resident #164 resided on a secure unit.</p> <p>A quarterly Minimum Data Assessment Set (MDS), dated 7/30/15, indicated the resident had severe cognitive impairment, and never or rarely made decisions.</p> <p>An Interdisciplinary Team (IDT) fall review note, dated 8/20/15, indicated "Will obtain urine specimen and dip to determine if further testing is needed, will remove over bed table, and request CBC [laboratory test] and CMP [laboratory test] from physician."</p>		<p>affected by the alleged deficient practice Resident #164 - Resident was reviewed by IDT and physician and determined there was no need for labs to be completed as previously provided and stated to surveyors. Resident #60 - Resident careplan and profiles were reviewed and updated as needed for clear communication of needs and direction for staff intervention. Resident #193 Resident careplan and profiles were reviewed and updated as needed for clear and resident specific communication of needs and direction for staff interventions. Resident #9 Resident careplans and profiles were reviewed and updated as needed for clear and resident specific communication of needs and direction for staff interventions. Handrails - All handrails were assessed and fixed accordingly as stated in this providers Preventative maintenance program. Call lights - Call light vendor has been scheduled the move of all call light boxes in resident bathrooms from in front to behind toilet as directed by surveyor during tour.</p> <p>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents with falls have the potential to be affected by the alleged practice. All residents utilizing</p>		

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	<p>The clinical record lacked any results from urine tests or blood laboratory tests after 8/14/15.</p> <p>A nurse note, dated 8/19/15, indicated the resident was confused and kept urinating on the floor even after multiple staff attempts to help and became aggressive.</p> <p>During an interview with the Director of Nursing (DON) on 9/8/15 at 2:57 p.m., she indicated the urine test and blood laboratory tests mentioned in the 8/20/15 IDT fall review note had not been obtained. She indicated she had a conversation with the physician and he wanted to wait to obtain the tests since the resident was on an antibiotic. Documentation of physician conversation was requested, and she indicated she was looking for it.</p> <p>On 9/8/15 at 3:50 p.m., the DON provided a copy of a faxed prescription, dated 9/8/15, from the physician. The prescription indicated Resident #164 fell on 8/19/15, was on antibiotics for pneumonia and physician "felt that labs were not indicated at that time since there was no evidence of mental status change."</p> <p>A2. The clinical record for Resident #60 was reviewed on 9/3/15 at 9:45 a.m.</p>		<p>handrails have the potential to be affected by the alleged practice. All residents needing to use call lights in bathrooms have the potential to be affected by the alleged practice. Review of all handrails occurred to ensure no sharp corners, edges or nails. All areas identified have been corrected. All call light boxes located on wall in front of toilet have been scheduled to be moved to behind toilet as directed by surveyor. Fall Care plans and patient profiles have been reviewed and updated as needed for proper communication to staff regarding resident specific interventions What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Preventative Maintenance schedule is in place and to be followed in relation to handrail monitoring, checking, and assessing each month as provided to surveyor. Preventative maintenance schedule in place and followed for call light monitoring each month as provided to surveyor. Staff re-educated on resident careplans and profiles allowing for staff knowledge of resident specific interventions based on specific needs. How the corrective action(s) will be monitored to ensure the</p>		

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	<p>Diagnoses for Resident #60 included, but were not limited to, dementia, congestive heart failure, and hypertension. Resident #60 resided on a secure unit.</p> <p>A quarterly MDS, dated 3/12/15, indicated Resident #60 was not steady and only able to stabilize with human assistance when moving on and off the toilet, moving from a seated to a standing position, and during surface to surface transfers. A quarterly MDS, dated 6/11/15, indicated Resident #60 was not steady and only able to stabilize with human assistance when moving on and off the toilet, moving from a seated to a standing position, and during surface to surface transfers. The assessment also indicated Resident #60 has severe cognitive impairment and rarely or never made decisions.</p> <p>A health care plan problem, dated 4/23/15, indicated Resident #60 was at risk for further falls related to "...needing varied assistance with mobility." Interventions for this problem included, but were not limited to, "assisting as needed" when the resident was up as desired with walking, and assisting with toileting in the mornings, before or after meals, prior to going to bed, and also throughout the night. The care plan did not indicate the amount of assistance</p>		<p>alleged deficient practice will not recur, i.e., what quality assurance program will be put into place Environmental CQI tool and Fall CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed</p>	

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	<p>needed.</p> <p>A nurses note, dated 8/23/15, indicated the nurse aide put the resident on the toilet and told her not to get up by herself. The aide went to help another resident to the bathroom and when returning to the resident heard the resident saying help. The resident was found on the floor. The resident had been incontinent at that time.</p> <p>An "OT [Occupational Therapy] - Therapist Progress & Discharge Summary", dated 7/28/15, indicated the goal was "the resident will be able to safely transition from sitting to standing and standing to sitting, increasing to stand by assistance [close enough to reach patient if assist needed]". The summary indicated the resident's goal was met on 7/28/15.</p> <p>A weekly summary, dated 8/10/15, indicated Resident #60 needed extensive assistance of one for all activities of daily living.</p> <p>A weekly summary, dated 8/17/15, indicated Resident #60 walked with a walker and assistance of one, and used assistance of one for transfers.</p> <p>During an interview with the DON on</p>			

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	<p>9/3/15 at 12:12 p.m., she indicated the fall risk assessments were an internal tool and not kept in the medical record. She indicated a fall risk assessment was completed at the time of admission or readmission and after a significant change for the residents.</p> <p>During an interview with CNA #5 on 9/9/15 at 8:33 a.m., she indicated she had worked at the facility for a year and a half. She indicated she worked multiple halls. She indicated Resident #60 needed help going to the bathroom and she stayed with the resident because the resident will stand up on her own.</p> <p>During an interview with CNA #6 on 9/9/15 at 9:09 a.m., she indicated she came to the locked units every day or every other day to help with activities or anything else. She indicated if a resident was on the locked unit they needed assistance and she would never leave a resident unattended on the toilet. She might allow for privacy but remain close to help if needed. She indicated residents on the locked unit did not have the cognitive ability to understand instructions such as "sit here and don't get up" or "use your call light" and "don't get up on your own." Some days they were able to use their call lights and some days they could not. CNA #6 indicated</p>			

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	<p>Resident #60 was not able to understand instructions such as "sit here and don't get up" or "wait until someone can help you." She indicated the residents on the locked unit did not have a safety awareness for themselves.</p> <p>During an interview with the DON, on 9/9/15 at 11:50 a.m., she indicated Resident #60 had a physician activity order to be up ad lib (as desired) with a walker, and further indicated therapy had indicated the resident had completed therapy and was able to be up ad lib.</p> <p>A 3. The clinical record for Resident #193 was reviewed on 9/4/15 at 2:50 p.m. Diagnoses for Resident #193 included, but were not limited to dementia, hypertension, and pain.</p> <p>An admission MDS, dated 8/11/15, indicated Resident #193 was not steady and only able to stabilize with human assistance when moving on and off the toilet, moving from a seated to a standing position, and during surface to surface transfers. The assessment also indicated Resident #193 has severe cognitive impairment and rarely or never made decisions.</p> <p>During an interview with the DON on 9/3/15 at 12:12 p.m., she indicated the</p>			

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	<p>fall risk assessments were an internal tool and not kept in the medical record. She indicated a fall risk assessment was completed at the time of admission or readmission and after a significant change for the resident.</p> <p>A health care plan problem, dated 8/4/15, indicated Resident #193 was at risk for falls. Interventions for this problem included, but were not limited to, "encourage the resident to ask for assistance, and assist the resident with his toileting needs."</p> <p>Resident #193 had an physician order in place from 8/4/15 to 8/21/15 for a wheelchair alarm and a bed alarm.</p> <p>A nurses note, dated 8/17/15, indicated "resident's girlfriend was at the desk and indicated the resident needed to go to the bathroom. The writer (nurse) asked the CNA to 'please immediately go down and toilet res. [resident] Supervisor aware.'" The resident's girlfriend returned to the desk and indicated the resident fell. The nurse went to the resident's room, the resident was sitting on the bathroom floor and the wheelchair alarm was not sounding. A new alarm was placed on the wheelchair.</p> <p>On 9/8/15 at 10:16 a.m., the DON</p>			

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	<p>provided a handwritten statement, on a plain white piece of paper, with no date or time as to when it was completed. The statement, signed by the DON, indicated, in regards to Resident #193's fall on 8/17/15, the significant other of Resident #193 reported to the nurse the resident needed to go to the bathroom. The CNA was instructed to assist the resident. The CNA completed what she was doing and before the CNA could get to Resident #193's room his significant other came out of his room and reported he fell. The nurse was with another resident and could not initially assist the resident with toileting. The alarm did not sound and was replaced. Resident #193 was known to "pull on alarms, fold up and tuck in closet per staff report".</p> <p>A4. The clinical record for Resident #9 was reviewed on 9/3/15 at 12:39 p.m. Diagnoses for Resident #9 included, but not limited to, dementia, hypertension, and depression.</p> <p>During an interview with the DON on 9/3/15 at 12:12 p.m., she indicated the fall risk assessments were an internal tool and not kept in the medical record. She indicated a fall risk assessment was completed at time of admission or readmission and after a significant change for the resident.</p>			

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	<p>An admission MDS, dated 6/8/15, indicated Resident #9 was not steady and only able to stabilize with human assistance when moving from a seated to a standing position, and during surface to surface transfers. The activity of moving on and off the toilet did not occur during assessment time frame. The assessment indicated Resident #9 had moderate cognitive impairment and made poor decisions, required cueing and supervision. A significant change MDS, dated 7/24/15, indicated Resident #9 was not steady and only able to stabilize with human assistance when moving from a seated to a standing position, and during surface to surface transfers. The activity of moving on and off the toilet did not occur during assessment time frame. The assessment indicated Resident #9 had severe cognitive impairment and never or rarely made decisions.</p> <p>A health care plan problem, dated 7/15/15, indicated Resident #9 had the potential for further falls. Interventions for this problem included, but were not limited to, "assist the resident with transfers and supervise during activities of daily living, have bed and chair alarms in place (check functioning/placement every shift), and check the resident every two hours for incontinence."</p>			

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	<p>A nurses note, dated, 8/26/15, indicated the resident was yelling for help from his bathroom. The resident was observed sitting on the floor of the bathroom in front of the sink. The resident indicated he was trying to get back in his chair.</p> <p>An fall event note, dated 8/26/15, indicated the resident was found sitting on the floor of his bathroom in front of the sink. Resident indicated he was trying to get back into his wheelchair.</p> <p>On 9/3/15 at 3:21 p.m., the DON provided a handwritten statement, on a plain white piece of paper, with no date or time as to when it was completed. The statement, signed by CNA #9, indicated the CNA was in another resident's room providing care when Resident #9 put himself on the toilet without her knowledge. Resident #9 then attempted to get himself off of the toilet without asking for assistance and fell. The CNA was in another resident's room at the time of the fall. Resident #9 was then re educated about asking for assistance.</p> <p>The nurses note, fall event note, and the statement from the CNA lacked any documentation/mention of an alarm sounding.</p>			

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	<p>Review of the current policy, revised on 2/2015, titled "Fall Management Program", provided by the DON on 9/3/15 at 9:52 a.m., included, but was not limited to, the following:</p> <p>"It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls.</p> <p>Procedure Fall risk... ...3. The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet.... ...Post fall... ...4. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. 5. All falls will be discussed by interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls..." B 1. On 9/2/15 at 2:45 p.m., the</p>			

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	<p>following facility hand rails were observed:</p> <p>The right hand mitered corner of the hand rail across from the bird cage was rough, with a sharp nail head protruding out.</p> <p>The right hand mitered corner hand rail across from the nurses station #2 was rough with sharp edges.</p> <p>The right hand mitered corner hand rail by the chairs in the small lounge next to "J" hall dining room was rough with sharp edges.</p> <p>The right hand mitered corner hand rail of "J" hall dining room was rough with sharp edges.</p> <p>The right hand mitered corner hand rail outside room 106 had a sharp nail head protruding out.</p> <p>The right hand mitered corner hand rail outside room 110 had a sharp nail head protruding out.</p> <p>The right hand mitered corner hand rail outside room 121 had a sharp nail head protruding out.</p> <p>The right hand mitered corner hand rail outside room 207 was rough with sharp</p>			

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	<p>edges.</p> <p>B2B. The maintenance supervisor was observed on 9/3/15 at 7:20 a.m., placing a brown putty substance on the hand rail in the hall between the bird cage and the nurses station #1.</p> <p>An environmental tour with the Administrator, Maintenance Supervisor, and Housekeeping Supervisor was made on 9/4/15 at 9:47 a.m., sharp areas remained on the hand rail across from the nurses station #2, by the chairs in small lounge next to "J" hall dining room, and the "J" hall dining room corner.</p> <p>During an interview on 9/4/15 at 10:13 a.m., the Administrator and the Maintenance Supervisor indicated the facility had no system in place to monitor the hand rails for sharp/rough edges.</p> <p>On 9/4/15 at 10:45 a.m., the Maintenance Supervisor presented the Preventative Maintenance Schedule for the month of September, indicating handrails were checked on 9/3/15. The bottom of the paper had an area for the Executive Director / General Manager Signature, this area had no signature or date.</p> <p>On 9/4/15 at 12:15 p.m., the Maintenance Supervisor presented the Preventative</p>			

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	<p>Maintenance Schedule for the month of June, indicating hand rails were checked on 6/12/15. The Executive Director / General Manager Signature was on the bottom of the page, and the date of 6/30/15. The Preventative Maintenance Schedule for the month of December, indicating hand rails were checked on 12/9/14. The Executive Director / General Manager Signature was on the bottom of the page, there was no date beside signature.</p> <p>B. 3. An environmental tour with the Administrator, Maintenance Supervisor, and Housekeeping Supervisor was made on 9/4/15 at 9:47 a.m., the Administrator measured the space from the toilet to the call light and the length of call light cord. The following observations were made:</p> <p>Room 224. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>Room 225. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>Room 228. The call light was located on</p>			

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	<p>the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>Room 232. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>Room 235. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>Room 237. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>Room 239. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>Room 245. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p>			

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F 0329 SS=E Bldg. 00	<p>Room 248. The call light was located on the wall at a distance of 2 feet across from the toilet and below the seat of the stool. This would cause the resident to have to reach bending over.</p> <p>The shower room located on the memory care unit #2, the call light was located 33 inches away from the toilet. This would cause the resident to have to reach bending over.</p> <p>During an observation on 9/4/15 at 10:17 a.m., the housekeeping supervisor sat on the toilet in room 224, she had to extend her shoulders past her knees to reach the call light cord, bending forward and becoming top-heavy.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose</p>			

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	<p>should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure statements of contraindication for gradual dose reductions contained a risk benefit analysis, failed to ensure resident specific depression symptoms were identified and monitored, failed to ensure antidepressant medication was not increased without documented depression symptoms and a medical assessment of the resident's depression and failed to monitor blood sugars for a resident with insulin dependent diabetes for 3 of 5 residents reviewed for unnecessary medication (Resident #31, #70, and #74)</p> <p>Findings include:</p> <p>1. On 9/2/15 at 1:58 p.m., Resident #31 was sitting in her room, in her recliner, in street clothes, with her eyes closed.</p>	F 0329	<p>F329 Unnecessary Drugs - It is the consistent practice of this Provider to ensure that each residents drug regimen is free from unnecessary drugs. What correctiveaction(s) will be accomplished for those residents found to have been affectedby the alleged deficient practice Resident #31 - Resident was seen by physician to review past med increases to ensure adequate assessment completed and validated the need of required med regimen.Resident #70 - careplan of resident was updated to identify specific signs and symptom of depression Resident #74 - Careplan of resident was updated to identify specific signs and symptom of depression. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be</p>	10/09/2015

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	<p>On 9/3/15 at 11:24 a.m., the resident was sitting in her room, in her recliner with her feet up, in street clothes, with her eyes closed.</p> <p>On 9/3/15 at 3:24 p.m., the resident was sitting in her room, in her recliner, in street clothes, with her eyes closed.</p> <p>During an interview on 9/4/15 at 10:37 a.m., the resident stated she "just doesn't feel good". She indicated she hurt and did not have the energy to get out of bed to eat. The resident was in pajamas and her breakfast tray was on the over the bed table next to her, untouched.</p> <p>On 9/4/15 at 1:51 p.m., the resident was changing positions in her recliner, in her room.</p> <p>On 9/4/15 at 2:27 p.m., the resident was sitting in her room, in her recliner watching television.</p> <p>On 9/4/15 at 3:36 p.m., the resident was in her wheelchair being assisted down the hall with shower supplies in her lap.</p> <p>The clinical record for Resident #31 was reviewed on 9/2/15 at 2:40 p.m. Diagnoses for Resident #31 included, but were not limited to, diabetes, dementia with depression, depressive psychosis,</p>		<p>taken All residents with GDRs have the potential to effected by the same alleged practice. Each resident will be reviewed based on schedule to ensure proper IDT and physician review with adequate documentation and assessment. All residents being treated for depression have the potential to be affected by the same alleged practice. Pharmacy will audit each resident treated for depression. Social service will update careplans to address resident specific behaviors, or specific signs and symptoms to be monitored. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Re-educate staff on patient specific care planning and education to determine and have knowledge of each resident specific signs and symptoms that are monitored for their depression. Monthly IDT team meeting with physician occurs to ensure all aspects of GDR are in place with team and physician assessment allowing for proper and complete documentation How the correctiveaction(s) will be monitored to ensure the alleged deficient practice will notrecur, i.e., what quality assurance program will be put into place Psychotropic Med CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2</p>				

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	<p>malaise and fatigue.</p> <p>Resident #31 had been on 20 milligrams (mg) of Celexa (an antidepressant medication), by mouth at bedtime since 11/25/14. On 6/10/15 the Celexa was increased to 30 mg by mouth at bedtime.</p> <p>A social services note, dated 3/3/15, indicated Resident #31 completed the PHQ9 (a section of the Minimum Data Assessment set related to depression) interview on 3/2/15 and scored 12/27, which indicated moderate depression. The note indicated Resident #31 stated she felt less pleasure in things often, little energy daily, difficulty sleeping daily, and restlessness daily.</p> <p>An IDT (Interdisciplinary Team) note, dated 5/13/15, indicated the resident had a 21 pound weight gain over the past 180 days.</p> <p>A social service note, dated 6/3/15, indicated the PHQ9 completed on 6/2/15 was 12/27, which indicated moderate depression. Resident #31 stated she felt sad, had little energy, poor appetite, and difficulty sleeping daily over the past 2 weeks. The resident stated the increase in mood was due to increased pain, stiffness and decreased mobility over the past 2 weeks. The resident was offered</p>		<p>consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed</p>	

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	<p>therapy services but declined them and stated it hurt her too much to participate.</p> <p>A nurses note, dated 6/3/15, indicated Resident #31 had completed her antibiotics for a urinary tract infection on 6/2/15.</p> <p>An IDT/care plan conference note, dated 6/10/15, indicated a care plan conference had been held with Resident #31's three daughters on 6/9/15. The family expressed concern about the resident's decreased intakes. The family also was concerned the resident made complaints of increased pain in her shoulders, legs, and feet. The resident was being treated by therapy for pain, but declined any therapy exercises. The family was concerned about the resident's complaints of not sleeping at night due to pain. The resident was noted to have increased signs and symptoms of depression. The family was concerned about the resident wearing pajamas during the day instead of clothing</p> <p>An IDT note, dated 6/11/15, indicated the PHQ9 completed on 6/2/15 was 12/27. The resident stated she felt sad, had little energy, poor appetite and difficulty sleeping daily over the past 2 weeks. The family also voiced concern related to the resident's increased signs and symptoms</p>			

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	<p>of depression. The family reported a history of severe depression and the use of Celexa 20 mg by the resident for 20 years. The physician assessed the resident and increased her Celexa to 30 mg. Will continue to observe for signs and symptoms of depression.</p> <p>A social services note, dated 9/1/15, indicated the PHQ9 completed on 9/1/15 was 12/27, still moderate depression. It indicated Resident #31 stated she felt depressed, had difficulty sleeping, little energy, and felt bad about self daily. The resident stated she felt all she did was sleep all the time.</p> <p>A social services note, dated 9/2/15, indicated the Social Services Assistant spoke with Resident #31 regarding her signs and symptoms of depression. The Social Services Assistant indicated the resident was more awake and talkative today and counseling services were declined by Resident #31. The resident stated "she just had not felt good yesterday and felt she answered yes to more questions than she would have today."</p> <p>A pharmacy consultant recommendation from the 5/6/15 record review indicated the resident had been receiving Celexa 20 mg at bedtime since 11/25/15 and asked</p>			

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	<p>if a Gradual Dose Reduction (GDR) may be attempted at this time. The physician checked the statement "Reduction is likely to impair the resident's function or increase distressed behavior". The physician signed the recommendation on 5/12/15.</p> <p>The clinical record contained provider progress notes dated 6/4/15, 6/23/15, 6/30/15, and 8/15/15. The provider progress notes lacked any mention of depression, and indicated the resident was pleasant or pleasant and confused in the "Psych" section of the note.</p> <p>During an interview with the Social Services Director on 9/8/15 at 10:29 a.m., she indicated behaviors were documented in the care plans and in the progress notes. She indicated Resident #31 was able to state feelings of depression.</p> <p>During an interview with the Social Services Assistant on 9/8/15 at 3:01 p.m., she indicated she had not found a progress note from the physician for an assessment related to the Celexa increase on 6/10/15 or any other documentation for the physician declined GDR on 5/12/15.</p> <p>2. The clinical record for Resident #31 was reviewed on 9/2/15 at 2:40 p.m.</p>			

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	<p>Diagnoses for Resident #31 included, but were not limited to, diabetes, dementia with depression, depressive psychosis, malaise and fatigue.</p> <p>A health care plan problem, dated 12/10/14, indicated Resident #31 had a diagnosis of diabetes and was at risk for adverse effects of hyperglycemia or hypoglycemia. Interventions for this problem included, but were not limited to, monitor blood sugars as ordered, document abnormal findings and notify the physician.</p> <p>A history of diabetic physician orders for Resident #31 included, but were not limited to, the following:</p> <p>a. Glucometer BID (twice a day), if blood glucose is less than 70 or greater than 300 call the physician. This order started on 6/19/15.</p> <p>From 12/22/14 to 5/16/15, Resident #31 had an order for a glucometer twice a day on Fridays, if blood glucose is less than 70 or greater than 250 call the physician.</p> <p>From 5/16/15 to 5/20/15, Resident #31 had an order for a glucometer twice a day, and to "indicate, in the physician binder, blood glucose results higher than 200. Call the physician if blood glucose</p>			

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	<p>results greater than 300."</p> <p>From 5/21/15 to 6/19/15, Resident #31 had an order for a glucometer twice a day, "if blood glucose less than 70 or greater than 250 call the physician."</p> <p>b. Humalog (insulin) 5 units, subcutaneous, once a day with dinner was initiated on 8/8/15.</p> <p>c. Lantus (insulin) 16 units, subcutaneous, at bedtime was initiated on 8/27/15.</p> <p>d. Humalog (insulin) 13 units, subcutaneous, once a day with lunch was initiated on 8/28/15.</p> <p>e. Tradjenta (a diabetes medication) 5 milligrams (mg), once a day was initiated on 6/18/15.</p> <p>f. Amaryl (a diabetes medication) 4 mg, twice a day was initiated on 6/30/15.</p> <p>g. Glipizide (a diabetes medication) 5 mg, once a day was initiated on 8/18/15.</p> <p>The May, June, July, and August 2015, Medication Administration Records (MAR) indicated the following:</p> <p>May 1, at 4:00 p.m., no blood sugar result documented</p>			

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	<p>May 29, at 4:00 p.m., no blood sugar result documented</p> <p>June 2, at 4:00 p.m., no blood sugar result documented</p> <p>June 11, at 4:00 p.m., no blood sugar result documented</p> <p>August 31, at 7:00 a.m., no blood sugar result documented</p> <p>August 31, at 4:00 p.m., no blood sugar result documented.</p> <p>On 9/8/15, at 9:26 a.m., the Director of Nursing provided a handwritten, signed statement from LPN #22 on a plain white piece of paper. Resident #31's name was written at the top of the page and the statement indicated "On the following dates 6/2/15 and 6/11/15. In regards to the residents 4 pm Blood sugars were done and were within call parameters. I am aware that call orders were below 70 and greater than 250 at these dates. Blood sugars were done and within limits."</p> <p>Review of the current facility policy, revised on 2/2015, titled "Blood Glucose Monitoring", provided by the DON, on 9/9/15 at 9:26 a.m., included, but was not limited to the following:</p> <p>"...PROCEDURE...</p> <p>...Blood glucose results will be</p>						

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	<p>documented on the Capillary Blood Glucose Monitoring Tool or on the medication administration record."</p> <p>The physician will be notified when the residents's blood glucose is outside the physician stated parameters..."3. Resident #74's clinical record was reviewed on 9/03/2015 at 3:39 p.m. Resident #74's current diagnoses, include but were not limited to, dementia with behavioral disturbances, depression and chronic pain.</p> <p>Resident #74 had a current physician's order for Abilify 2 mg (an antipsychotic medication used in conjunction with an antidepressant to treat depression) 1 time daily for depression. This order originated 5/7/15.</p> <p>Resident #74 had a current physician's order for Lexapro 20 mg (an antidepressant medication) one time daily.</p> <p>Resident #74's record contained a definition of depressive symptoms. Resident #74's record lacked a resident specific indication of how Resident #74's depression symptoms displayed itself. Resident #74's record lacked a method of ongoing monitoring for depression symptoms.</p>			

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	<p>On 8/31/2015 at 2:35 p.m., Resident #74 was awake and conversational resting on his bed.</p> <p>On 9/01/2015 at 10:45 a.m., Resident #74 was visiting in his room with his spouse.</p> <p>On 9/03/2015 at 9:46 a.m., Resident #74 was visiting in his room with his spouse.</p> <p>On 9/03/2015 at 10:25 a.m., Resident #74 was in his room calmly receiving assistance from a staff member.</p> <p>On 9/03/2015 at 11:43 a.m., Resident #74 was visiting in his room with his spouse.</p> <p>On 9/04/2015 at 8:41 a.m., Resident #74 finished his breakfast and walked down the hall with his walker to his room. He was accompanied by his spouse.</p> <p>4. Resident #70's clinical record was reviewed on 9/3/15 at 11:02 a.m. Resident #70's current diagnoses included, but were not limited to, dementia with behavioral disturbances and depression.</p> <p>Resident #70 had a current physician's order for sertaline 100 mg (an antidepressant medication) one time daily. This order originated 6/6/15.</p> <p>Resident #70's record contained a definition of depressive symptoms. Resident #70 record lacked a resident</p>			

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	<p>specific indication of how Resident #70's depression symptoms displayed itself Resident #70's record lacked a method of ongoing monitoring for depression symptoms.</p> <p>On 9/01/2015 at 10:43 a.m., Resident #70 was seated in the activity/dining area at the over the bed table. She was calm.</p> <p>On 9/03/2015 at 9:41 a.m., Resident #70 was seated in the activity/dining area at the over the bed table. She was calm.</p> <p>On 9/3/15 at 9:49 a.m., Resident #70 was in her wheelchair seated at an over the bed table. She was calm.</p> <p>On 9/03/2015 at 10:00 a.m., Resident #70 accidentally dropped her muffin to the floor. She made several attempts to reach for the muffin but could not reach it. She stopped reaching for the muffin and sat at the over the bed table.</p> <p>On 9/03/2015 at 10:16 a.m., Resident #70 sat rubbing her table.</p> <p>On 9/03/2015 at 10:20 a.m., Resident #70 took off her clothing protector and put it on her table.</p> <p>On 9/03/15 at 10:27 a.m., Resident #70 tried to push her wheelchair away from</p>			

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	<p>the over the bed table.</p> <p>On 9/03/2015 at 10:43 a.m., Resident #70 sat facing her over the bed table in her standard dining location. She manipulated the clothing protector that was on the over the bed table.</p> <p>On 9/03/2015 at 10:44 a.m., Resident #70 called out.</p> <p>On 9/03/2015 at 2:34 p.m., Resident #70 was seated in the activity/dining room at the over the bed table.</p> <p>On 9/04/2015 at 8:47 a.m., Resident #70 sat in her wheelchair at an over the bed table with a drink and a magazine on the table.</p> <p>On 9/04/2015 from 9:27 a.m. to 9:43 a.m., Resident #70 sat in the same location facing the over the bed table. A trivia event was offered during this time.</p> <p>During an 9/8/15, 12:41 p.m., interview Social Services Director #16, indicated the facility did not identify and monitor resident specific symptoms of depression. She additionally indicated symptoms of depression were monitored quarterly by resident interview during the MDS assessment process. She indicated there was not a system of more frequent</p>			

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F 0356 SS=C Bldg. 00	<p>symptom monitoring for cognitively impaired residents who were not good historians.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-42(b)(2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p>			

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	<p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the list of "nursing staff on duty" was posted and updated on a daily basis as required. This had the potential to effect 145 of 145 residents who resided in facility.</p> <p>Findings include:</p> <p>During an observation on 8/31/15 at 9:43 a.m., the "nurse staff on duty" form posted at nurses station , was dated 8/25/15.</p> <p>During an observation on 9/8/15 at 8:41 a.m., the "nurse staff on duty" form posted was dated 9/4/15. LPN #22 verified the date of the posting was 9/4/15.</p> <p>During an interview on 9/8/15 at 8:43 a.m., the Director of Nursing indicated the scheduling coordinator changed the "nurse staff on duty" form daily.</p> <p>During an interview on 9/8/15 at 8:43 a.m., the Medical Record Nurse indicated the Scheduling Coordinator did not work on weekends.</p>	F 0356	<p>F356 Nursing Posting - It is the consistent practice of this Provider to post nursing staffing daily as required by law. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice The nursing staffing on duty was posted as required later in the day as required. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents in the facility have the potential to be affected by the alleged practice. Nurse manager will post the nurse staff on duty at the beginning of each shift each day What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Re-educated nursing managers on the system of posting staff on duty sheet. Daily rounds by nursing managers will occur to validate posting of nurse staffing sheet. How the corrective action(s) will be monitored to ensure the alleged deficient practice will</p>	10/09/2015

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F 0371 SS=F Bldg. 00	<p>During an interview on 9/8/15 at 9:56 a.m., the Director of Nursing indicated the unit nurse changed the "nurse staff on duty" form on weekends.</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review and interview, the facility failed to ensure the dishmachine sanitizer solution was at the appropriate concentration to sanitize dishes for 1 of 2 kitchen observations. This deficient practice had the potential to effect 140 of 145 residents that received meals from the kitchen.</p> <p>Findings include:</p> <p>The initial tour of the kitchen was made on 8/31/15 at 9:38 a.m., with the Certified Dietary Manager (CDM) present. The CDM indicated the dishmachine didn't quite get up to 180 degrees during the rinse cycle and bleach</p>	F 0371	<p>not recur, i.e., what quality assurance program will be put into place Nursing round sheet to be used daily by nurse managers to ensure staff posting up each day. Nursing round sheet to include monitoring of staffing sheet posted as well as other pertinent nursing and care items.</p> <p>F371 Food Precure, Store/Prepare/Serve-Sanitary: It is the consistent practice of this facility to precure food, store, prepare, distribute and serve food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice This provider will IDR this tag based on corrective actions taken prior to survey and listed: Test strips were attained in between GFS vendor visits and verified the dishmachine was running with proper sanitizer. GFS vendor was called in before and during survey to verify the machine was running properly with sanitizer.</p>	10/09/2015

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	<p>had been added to the water to sanitize the dishes. He indicated this practice started on 8/28/15.</p> <p>Dietary Aide #7 was observed washing dishes and the rinse cycle on the dishmachine indicated 178 degrees on 8/31/15 at 9:44 a.m. Dietary Aide #7 indicated she did not test the sanitizer concentration. She indicated she just made sure the hose was connected.</p> <p>On 8/31/15 at 9:45 a.m., the CDM indicated the facility did not have any test strips to test the sanitizing solution of the dishmachine. He indicated the technician took the strips with him on 8/28/15, after testing the solution. He indicated the sanitizing solution had not been checked since installation. He indicated he just assumed it worked properly. He indicated he would order some test strips and they would arrive the next day.</p> <p>The "High Temp Dishmachine Temperature Log" was provided by the CDM on 9/4/15 at 9:23 a.m. The logs indicated the rinse temperatures should be a minimum of 180 degrees. The logs indicated the rinse temperatures were 175 for lunch dishes on 8/27/15, 178 degrees for breakfast dishes on 8/31/15, and 176 degrees for breakfast dishes on 8/31/15.</p>		<p>Dishmachine was serviced and proper high temps in place. The intent of serving residents under sanitary conditions was and is currently being met. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</p> <p>All residents using the dishes from the main kitchen have the potential to be affected by the same alleged practice. Proper sanitizer was placed on the dishmachine validated by GFS before and during survey along with test strips of this Provider.</p> <p>Dishmachine temps taken daily to ensure machine is at proper temps. When temps are not reached proper action is taken as done in this situation of calling GFS vendor for sanitizer solution until temps reached as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Dishmachine temps will be taken daily when in use. Logs are kept to verify temps. Extra Test strips are available on site to ensure consistent and daily availability if needed when temps fall below standards and sanitizer is required. How the corrective action(s) will be monitored to ensure the alleged deficient practice will</p>				

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F 0465 SS=E Bldg. 00	<p>The revised, 4/11, "Recording Dish Machine Temperature/Sanitizer" Policy was provided by the CDM on 9/4/15 at 9:23 a.m. The policy indicated dishwashing staff "will monitor and record dish machine temperatures and/or sanitizer concentration to assure proper sanitizing of dishes." A log would be posted near the dish machine. Staff would be trained to record the dish machine temperature for the wash and rinse cycles and the sanitizer concentration (if appropriate) at each meal. The Dietary Services Manager was to spot check the logs to assure temperatures/sanitizer concentrations were appropriate.</p> <p>On 9/9/15 at 9:30 a.m., the administrator indicated the facility serves 140 resident meals from the kitchen.</p> <p>3.1-20(i)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure resident bathroom floors were clean and</p>	F 0465	<p>not recur, i.e., what quality assurance program will be put into place Kitchen Sanitation CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed</p> <p>F465 Safe Functional Sanitary Comfortable environment - It is the consistent practice of this Provider to provide a safe,</p>	10/09/2015			

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	<p>neat for 9 of 9 rooms reviewed on the Memory Care 2 Unit. This deficient practice had the potential to impact 18 residents. (Rooms 103, 104, 106, 107, 110, 111, 112, and 114)</p> <p>Findings include:</p> <p>On 9/4/15 at 10:30 a.m., the Housekeeping Supervisor provided 16 pages titled "Deep Cleaning Calendar". She indicated this was a monthly deep cleaning schedule of residents' rooms, There was no documentation of deep cleaning completed from April 2015 through August 2015.</p> <p>The following observations of residents' rooms were made:</p> <p>Room 103 on 9/1/15 at 12:34 p.m., the bathroom had a brown/gold substance at the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar" indicated deep cleaning completed 6/12/15.</p> <p>Room 104 on 9/1/15 at 12:37 p.m., the bathroom had a black substance at the base of the toilet, a black substance with wax build up at the threshold. The "Deep Cleaning Calendar" indicated deep cleaning was completed on 6/8/15.</p>		<p>functional, sanitary, and comfortable environment for residents, staff and the public</p> <p>This facility is requesting IDR for this tag. Staff were not present during identification of alleged environmental issues on 9/1/15 as stated by surveyor; On environmental tour 9/3/15 with surveyor, these cited items were not identified or shown to staff. When cleaning these cited bathrooms, staff could not identify areas of concern as stated in 2567. Specific, detailed and approved renovations that addresses all bathrooms identified by surveyor in this 2567 were provided and left at facility and not placed in the record on file. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Room 103 bathroom - substance at base of tub is not evident. Black substance at threshold not</p>	

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	<p>Room 106 on 9/1/15 at 12:39 p.m., the bathroom had a black substance at the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar" indicated no deep cleaning was completed from April 2015 through August 2015.</p> <p>Room 107 on 9/1/15 at 12:41 p.m., the bathroom had a black substance at the base of the bath tub, a discoloration on the wall left of the sink, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar" indicated deep cleaning was completed on 4/17/15.</p> <p>Room 110 on 9/1/15 at 12:43 p.m., the bathroom threshold had a black substance with wax build up. The "Deep Cleaning Calendar" indicated deep cleaning was completed on 4/7/15.</p> <p>Room 111 on 9/1/15 at 12:45 p.m., the bathroom had a black substance around the the base board behind the stool, a black substance with wax build up at the threshold. The "Deep Cleaning Calendar" indicated deep cleaning was completed on 4/14/15.</p> <p>Room 112 on 9/1/15 at 12:47 p.m., the</p>		<p>evident in this bathroom. Wax buildup not present as these bathrooms do not have or use wax. This bathroom was again deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 104 bathroom - there was no black substance found at base of toilet; there was dirt at threshold and cleaned; there was no wax buildup found as this flooring does not have wax. This bathroom was deep cleaned regardless of citation or findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 106 - substance at base of tub is not evident. Black substance at threshold not evident in this bathroom. Wax buildup not present as these bathrooms do not have or use wax. These items were not found in this bathroom. This bathroom was again deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 107 - substance at base of tub is not evident. Black substance at threshold not evident in this bathroom. Wax</p>	

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	<p>bathroom had a black substance around the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar" indicated deep cleaning was completed on 6/26/15.</p> <p>Room 114 on 9/1/15 at 12:48 p.m., the bathroom had a black substance around the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar" indicated deep cleaning was completed on 4/13/15.</p> <p>On 9/4/15 at 1:41 p.m., the housekeeping supervisor provided "Housekeeping Policy and Procedures". The policy indicated "Cleaning Guidelines" were "Each hall housekeeper should do a minimum of one resident room deep clean per day to assure that all rooms have been deep cleaned each month. Missed rooms will be scheduled for the next day or as assigned."</p> <p>During an interview on 9/4/15 at 12:52 p.m., the Administrator provided information, dated August 10th 2015, indicating Riverwalk Village Remodels for rooms 102-114. There was no date indicating the starting of the remodeling. There was an approved signature with the date 8/18/15</p>		<p>buildup not present as these bathrooms do not have or use wax. The wall was repaired and painted. This bathroom was deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 110 - The threshold was cleaned and free of dirt. Wax buildup not present as this bathroom does not have wax. This bathroom was again deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 111 - the base board behind the toilet was cleaned. Threshold was cleaned free of dirt and no wax build up was evident as this floor does not have wax. This bathroom was deep cleaned regardless of citation and alleged findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room112 - no black substance was evident at or on the tub. The tub was cleaned inside and out. The threshold was cleaned. No wax build up or substance was evident. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal</p>				

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	<p>During an interview on 09/04/15 at 1:03 p.m., the housekeeping supervisor indicated the thresholds in the bathrooms on the 2 memory care units had not been stripped and waxed in over a year because the facility was approved for remodeling.</p> <p>The 8/31/15, facility completed "Bed Inventory" form indicated rooms 103, 104, 106, 107, 110, 111, 112, and 114 were licensed to house 2 residents per room. This resulted in the potential to impact 18 residents.</p> <p>3.1-19(f)</p>		<p>of tub as described and provided to surveyor. Room 114 - no black substance was evident at the base of the tub; the threshold was cleaned and free of dirt.</p> <p>There was no wax build up evident as this bathroom does not have wax. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. These identified bathrooms were all deep cleaned regardless of lack of evidence or findings. When this Provider was on environmental tour with surveyor on 9/3/15, these items were not pointed out or shown to facility staff. The surveyor states that these items were seen by ISDH on 9/1/15 when no staff present. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents with bathrooms have the potential to be affected by the alleged practice. These identified bathrooms were deep cleaned regardless of findings and lack of evidence. All bathrooms were audited and assessed for cleanliness in the entire building. Any environmental findings including black substance, wax build up, dirt at thresholds or marks on walls were identified, cleaned and/or repaired. What measures will be put into place</p>	

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F 0520 SS=E Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.		or what systemic changes you will make to ensure that the alleged deficient practice does not recur Deep cleaning schedules are scheduled and continue to be followed for resident rooms and bathrooms. Home office completes semi-annual environment assessment. Housekeeping staff were re-educated on daily cleaning schedules, deep cleaning schedules, general cleaning and expectations for resident and bathroom cleanliness. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place Environmental CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed	

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	<p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility's QAA Committee failed to identify and implement a plan of action to address environmental cleanliness on Memory Care Unit 2. This deficient practice had the potential to impact 18 residents. (Rooms 103, 104, 106, 107, 110, 111, 112, and 114)</p> <p>Findings include:</p> <p>1. On 9/4/15 at 10:30 a.m., the Housekeeping Supervisor provided 16 pages titled "Deep Cleaning Calendar". She indicated this was a monthly deep cleaning schedule of residents rooms, There was no documentation of deep cleaning completed from April 2015 through August 2015.</p>	F 0520	F520 QA Committee - It is the consistent practice of the Provider to hold monthly QA meetings including all managers and medical Director; This QA committee consistently identifies and implements plans of corrections based on audit findings. This facility is requesting IDR for this tag. Staff were not present during identification of alleged environmental issues on 9/1/15 as stated by surveyor; On environmental tour 9/3/15 with surveyor, these cited items were not identified or shown to staff. This facility has monthly meetings with all managers and medical director. We provided dates and audits to Toni Maley surveyor related to environmental audits that included rooms that have been cited. Audit Findings nor action plans were requested to	10/09/2015

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	<p>The following observations of resident's rooms were made during the following dates and times:</p> <p>Room 103 on 9/1/15 at 12:34 p.m., the bathroom had a brown/gold substance at the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar", indicated deep cleaning completed 6/12/15.</p> <p>Room 104 on 9/1/15 at 12:37 p.m., the bathroom had a black substance at the base of the toilet, a black substance with wax build up at the threshold. The "Deep Cleaning Calendar", indicated deep cleaning was completed on 6/8/15.</p> <p>Room 106 on 9/1/15 at 12:39 p.m., the bathroom had a black substance at the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar", indicated no deep cleaning was completed from April 2015 through August 2015.</p> <p>Room 107 on 9/1/15 at 12:41 p.m., the bathroom had a black substance at the base of the bath tub, a discoloration on the wall left of the sink, and a black substance with wax build up at the threshold. The "Deep Cleaning</p>		<p>validate action already taken by this Provider on these items prior to survey were not asked for nor discussed to validate CMS standards of "Good faith attempts by the committee to identify and correct quality deficiencies will not be used as basis for sanctions." What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Room 103 bathroom - substance at base of tub is not evident. Black substance at threshold not evident in this bathroom. Wax buildup not present as these bathrooms do not have or use wax. This bathroom was again deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 104 bathroom - there was no black substance found at base of toilet; there was dirt at threshold and cleaned; there was no wax buildup found as this flooring does not have wax. This bathroom was deep cleaned regardless of citation or findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 106 - substance at base of tub is not evident. Black substance at threshold not</p>	

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	<p>Calendar", indicated deep cleaning was completed on 4/17/15.</p> <p>Room 110 on 9/1/15 at 12:43 p.m., the bathroom threshold had a black substance with wax build up. The "Deep Cleaning Calendar", indicated deep cleaning was completed on 4/7/15.</p> <p>Room 111 on 9/1/15 at 12:45 p.m., the bathroom had a black substance around the the base board behind the stool, a black substance with wax build up at the threshold. The "Deep Cleaning Calendar", indicated deep cleaning was completed on 4/14/15.</p> <p>Room 112 on 9/1/15 at 12:47 p.m., the bathroom had a black substance around the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar", indicated deep cleaning was completed on 6/26/15.</p> <p>Room 114 on 9/1/15 at 12:48 p.m., the bathroom had a black substance around the base of the bath tub, and a black substance with wax build up at the threshold. The "Deep Cleaning Calendar", indicated deep cleaning was completed on 4/13/15.</p> <p>On 9/4/15 at 1:41 p.m., the housekeeping</p>		<p>evident in this bathroom. Wax buildup not present as these bathrooms do not have or use wax. These items were not found in this bathroom. This bathroom was again deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 107 - substance at base of tub is not evident. Black substance at threshold not evident in this bathroom. Wax buildup not present as these bathrooms do not have or use wax. The wall was repaired and painted. This bathroom was deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 110 - The threshold was cleaned and free of dirt. Wax buildup not present as this bathroom does not have wax. This bathroom was again deep cleaned regardless of citation and findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 111 - the base board behind the toilet was cleaned. Threshold was cleaned free of dirt and no wax build up was evident as this floor does not</p>				

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	<p>supervisor provided "Housekeeping Policy and Procedures". The policy indicated "Cleaning Guidelines", "Each hall housekeeper should do a minimum of one resident room deep clean per day to assure that all rooms have been deep cleaned each month. Missed rooms will be scheduled for the next day or as assigned."</p> <p>During an interview on 9/4/15 at 12:52 p.m., the Administrator provided information, dated August 10th 2015, indicating Riverwalk Village Remodels for rooms 102-114. There was no date indicating the start of the remodeling. There was an approved signature with the date 8/18/15</p> <p>During an interview on 09/04/15 at 1:03 p.m., the housekeeping supervisor indicated the thresholds in the bathrooms on the 2 memory care units have not been stripped and waxed in over a year because the facility is approved for remodels.</p> <p>The 8/31/15, facility completed "Bed Inventory" form indicated rooms 103, 104, 106, 107, 110, 111, 112, and 114 were licensed to house 2 residents per room. This resulted in the potential to impact 18 residents.</p>		<p>have wax. This bathroom was deep cleaned regardless of citation and alleged findings. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room112 - no black substance was evident at or on the tub. The tub was cleaned inside and out. The threshold was cleaned. No wax build up or substance was evident. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. Room 114 - no black substance was evident at the base of the tub; the threshold was cleaned and free of dirt.</p> <p>There was no wax build up evident as this bathroom does not have wax. This bathroom is scheduled to be completely remodeled with new flooring, sink, toilet and removal of tub as described and provided to surveyor. These identified bathrooms were all deep cleaned regardless of lack of evidence or findings. When this Provider was on environmental tour with surveyor on 9/3/15, these items were not pointed out or shown to facility staff. The surveyor states that these items were seen by ISDH on 9/1/15 when no staff present. How will you identify other residents having the potential to be affected by the same alleged deficient practice</p>	

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	<p>During a 9/9/2015, 8:52 a.m., interview, the Administrator indicated the QAA Committee had reviewed environmental cleanliness during the last quarter. He indicated he believed all areas of floor concern would be corrected following the renovation. He indicated there was no exact start date for the renovation.</p> <p>3.1-52(b)(2)</p>		<p>and what corrective action will be taken All residents with bathrooms have the potential to be affected by the alleged practice. These identified bathrooms were deep cleaned regardless of findings and lack of evidence. All bathrooms were audited and assessed for cleanliness in the entire building. Any environmental findings including black substance, wax build up, dirt at thresholds or marks on walls were identified, cleaned and/or repaired. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Deep cleaning schedules are scheduled and continue to be followed for resident rooms and bathrooms. Home office completes semi-annual environment assessment. Housekeeping staff were re-educated on daily cleaning schedules, deep cleaning schedules, general cleaning and expectations for resident and bathroom cleanliness. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place Environment CQI tool and monthly QA Schedule will be completed weekly x 4, monthly x6, and quarterly thereafter maintaining 2 consecutive</p>	

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			quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed		