

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/23/2015
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NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
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F000000	<p>This survey was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: February 17, 18, 19, 20, and 23, 2015</p> <p>Facility number: 000310 Provider number: 155443 AIM number: 100288970</p> <p>Survey team: Karen Lewis, RN -TC Tina Smith-Staats, RN Toni Maley, BSW Ginger McNamee, RN (2/18/15, 2/19/15, 2/20/15, 2/23/15) Angela Selleck, RN (2/18/15, 2/19/15, 2/20/15, 2/23/15)</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 6 Medicaid: 53 Other: 8 Total: 67</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F000244 SS=E	<p>Quality review completed on February 25, 2015 by Randy Fry RN.</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on observation, record review and interview, the facility failed to respond to and resolve grievances brought forth by the Resident Council in a timely manner for four of eight months of Resident Council Meeting Minutes reviewed.</p> <p>Findings include:</p> <p>During an anonymous interview on 2/18/15 at 2:08 p.m., the resident stated, "If I don't sleep with my door shut I can hear them slamming the doors shut. Why can't they shut the doors without slamming them?" The resident room was located at the far end of the 300 hall, furthest away from the nursing station.</p> <p>On 2/23/15 at 2:00 p.m., with permission from the Resident Council President, the Resident Council minutes for the months of May 2014 through January 2015, were</p>	F000244	F 244 Currently noise levels are kept to a reasonable decibel at all times with special consideration at shift change and at bedtime and throughout the night. Residents at the far end of 300 hall are satisfied with the current noise control. Further, concerns from Resident Council meetings are given to the appropriate Department Head by the Activity Director at the next daily CQI meeting following the Resident Council meeting. Concerns will be addressed within 48-72 hours after receipt by the appropriate Department Head. The Department Head will report back to the Administrator and the Activity Director at the daily CQI meeting (again, within 48-72 hours after receipt of the concern). The Administrator will see that the concern is discussed and that the person(s) who initiated the concern is informed of the outcome. If the concern	03/25/2015

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	<p>reviewed.</p> <p>Resident Council Meeting minutes dated, 5/22/14 indicated the residents voiced concern about staff talking loudly and slamming the doors at night. The facility's response was to educate staff on the "importance of being quiet at night".</p> <p>Resident Council Meeting minutes dated, 9/30/14 indicated the residents voiced concern about staff slamming the doors at night. The facility's response was to discuss trying to get the doors to close more quietly with maintenance and to educate the staff on closing the doors "as gently as possible".</p> <p>Resident Council Meeting minutes dated, 10/30/14 indicated the residents voiced concern about staff slamming the doors at night. The facility's response was to educate the staff.</p> <p>Resident Council Meeting minutes dated, 1/29/15 indicated the residents voiced concern about staff slamming the doors at night. The facility's response was to educate the staff.</p> <p>An attendance record for an inservice, regarding "keeping hallway noise levels to a whisper and not letting doors slam", dated, 1/30/15 at 3:00 p.m. was provided</p>		<p>involves an individual resident, the resolution/outcome will be shared with that resident upon resolution. If the concern is a group concern, the resolution/outcome will be shared with the Resident Council at the next meeting. The President of Resident Council will be notified upon resolution/outcome. Any concern of an emergent nature will be handled by immediately reporting the concern to the Administrator so it can be addressed immediately. The Administrator will monitor Resident Council meeting minutes month to month to see that all "old business" has been addressed and does not appear on subsequent months unresolved. The QA Committee will develop Action Plans as appropriate for any unsatisfactorily/unresolved issues. This monitoring will be ongoing The Administrator/Designee will monitor noise levels by interviewing 2 alert and oriented residents on each hall weekly until 4 consecutive weeks of zero negative findings are achieved. This monitoring will continue for at least 6 months, and then re-evaluate the need to continue if unresolved. Any concerns will be addressed as discovered. All residents have the potential to be affected by this finding. At an all staff inservice held 3/11/2015</p>		

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F000282 SS=D	<p>Director of Nursing (DON). Eighteen names were documented on the attendance record. The attendance record did not specify which shift the attendees worked.</p> <p>An attendance record for an inservice, regarding "slamming doors", dated 2/10/15 was provided. Twenty-eight names were documented on the attendance record. The attendance record did not specify which shift the attendees worked.</p> <p>During an interview on 2/ 23/15 at 2:33 p.m., the DON indicated the staff were receiving ongoing inservices on noise reduction on the night shift.</p> <p>3.1-3(I)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure medications were transcribed and medication orders were followed in a timely, correct manner</p>	F000282	<p>and 3/12/2015 the following was reviewed: A. What is the function of Resident Council? B. What are Resident Rights? C. How are concerns addressed at Resident Council? (By whom? Follow up? D. Who spearheads Resident Council meetings? E. Noise levels in the "home" of the residents F. Timely addressing of Resident concerns Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings the results of the noise level monitoring by the Administrator/Designee will be reviewed as well as the concerns of the most recent Resident Council meeting. Any issues will have been addressed as discovered, however any patterns will be addressed via an Action Plan written by the QA Committee and followed up on by the Administrator weekly until resolved.</p> <p>Resident #45 and Resident #61 are receiving their medications at the prescribed doses. Going forward, these residents and all residents will receive meds timely</p>	03/25/2015			

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	<p>for 2 of 5 residents reviewed for drug regimen review (Resident #45 and #61).</p> <p>Findings include:</p> <p>1. Resident #45's clinical record was reviewed on 2/19/15 at 10:01 a.m. Resident #45's current diagnoses included, but were not limited to, anxiety, depression and dementia with behavioral disturbances.</p> <p>Resident #45 had a 6/24/15 pharmacy recommendation for a gradual dose reduction for three psychoactive medications which included Seroquel. On, 6/25/14, the physician responded to this recommendation with an order to reduce Seroquel to 37.5 mg daily. The "Telephone Order" to decrease the medication Seroquel and begin administering to Resident #45 was not transcribed (written and started as a medication) until 6/27/14 (a period of 2 days after the doctor wrote the order). The medication administration record indicated Resident #45 did not start receiving the Seroquel 37.5 mg until 6/28/15.</p> <p>Resident #45 had a 12/1/14 pharmacy recommendation for a gradual dose reduction for three psychoactive medications which included Clonazepam</p>		<p>after the med or dosage change is ordered. Any resident who receives medication in the facility has the potential to be affected by this finding. All residents have had their records reviewed and their med sheets reflect the ordered doses. Upon receipt of a medication order or a change in dose of a medication, the nurse receiving the order will process the order which includes transcribing it to the medication sheet and ordering it from the pharmacy. If the med is not received prior to the time it is due (next med pass time it is due per facility med pass schedule), it will be obtained from the EDK. If it is not in the EDK, it will be obtained in the next scheduled pharmacy delivery. If it does not arrive in the next pharmacy delivery, pharmacy will be notified and will forward the med or make arrangements for the med to be obtained via the backup pharmacy. The DON/Designee will monitor all new med orders at the daily CQI meetings. The DON/Designee will monitor 5 med orders daily for timeliness of initiation of the med administration. This monitoring will continue for at least 6 months, and then re-evaluate the need to continue if unresolved. Afterwards, random weekly monitoring will occur. Any concerns will be addressed as discovered. At an inservice held on 3/11/2015 and</p>				

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	<p>(Klonopin). On 12/11/14, the physician responded to this recommendation with an order to decrease Klonopin to 0.5 mg daily at bed time. The "Telephone Order" to decrease the medication Klonopin and begin administering to Resident #45 was not transcribed (written and started as a medication) until 12/18/14 (a period of 7 days after the doctor wrote the order).</p> <p>Resident #45's record lacked any documentation regarding the delay in the reduction of the medications Seroquel and Klonopin.</p> <p>During a 2/20/15, 9:40 a.m., interview, the Director of Nursing (DON) indicated when the pharmacist makes recommendations for a resident's drug regimen, the recommendations are given to the DON. The DON then ensures the physician is made aware of the fax either in person during a visit or via fax.</p> <p>During a 2/20/15, 10:26 a.m., interview, the Assistant Director of Nursing reviewed Resident #45's record and indicated she would need to further investigate the delay in the transcription of the medications Seroquel and Klonopin.</p> <p>During a 2/23/15, 12:49 p.m., interview,</p>		<p>3/12/2015 ,for nursing staff who transcribe orders and/or administer meds the following was reviewed: A. Medication Administration 1. Complete Order 2. Transcribing orders (Process) a. Who's responsibility? b. Timeliness/Completeness c. Documentation d. Med availability/Whom to notify if not available e. Follow up Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as appropriate. At the monthly QA meeting the monitoring of the DON/Designee for timely med administration following an order will be reviewed, however any concerns will have been addressed upon discovery. Any patterns identified will be addressed via an Action Plan written by the QA Committee and monitored weekly by the Administrator until resolved.</p>				

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	<p>the DON indicated there should not have been a delay in transcribing the "Telephone Orders" for Resident #45. The facility had determined there had been errors when the doctor was in the facility and writes orders. She additionally indicated she could not determine why there was a delay on the, 6/24/14, recommendation which had been communicated to the physician via FAX. She indicated the facility was currently developing a plan of action to correct this concern.</p> <p>2. Resident #61's clinical record was reviewed on 2/19/2015 at 10:04 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, delusional disorder, and major neuro cognitive disorder.</p> <p>The resident had an 8/5/14, physician's order to change the trazadone [for insomnia] from 100 mg at bedtime to 50 mg prn [as needed] at bedtime.</p> <p>Review of the September, October, November, December, 2014, January and February, 2015, Physician's Orders indicated the resident was receiving trazadone hcl 50 mg by mouth at bedtime.</p> <p>During an interview with LPN #1 on</p>						

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	<p>2/20/15 at 11:55 a.m., he indicated the resident received trazadone 50 mg as a routine medication at bedtime. He indicated he could not find an order for the medication to be changed from an as needed medication to a routine medication.</p> <p>During an interview with the Director of Nursing on 2/23/15 at 11:50 a.m., she indicated she could not find an order to change the trazadone from an as needed medication to a routine medication.</p> <p>3. The 6/19/14, updated "Physician's Orders" policy was provided by the Director of Nursing on 2/20/15, at 12:48 p.m. The policy indicated physician's orders may be obtained by telephone or handwritten on the Physician Order Sheet. Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet or the telephone order sheet if it is a verbal order, and the Medication Administration Record (MAR) or treatment record (TAR). The policy indicated: "...The following steps are initiated to complete documentation: a. Clarify the order b. Enter the orders on the medications order and fax the medication order to the</p>				

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F000323 SS=E	<p>provider pharmacy.</p> <p>c. Transcribed newly prescribed medications on the MAR or TAR. If a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing "DC's" and the date. Enter the new order on the MAR or TAR.</p> <p>d. After completion, document each medication order noted on the physician's order form with date, time, and signature...."</p> <p>3.1.35(g)(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. Based on observation, record review and interview, the facility failed to correct identified unsafe toilet risers after a fall for 1 of 3 residents reviewed for falls(Resident #60). This deficient practice had the potential to effect 16 residents currently living on the 300 and 400 halls and 23 residents living on the Hope Springs locked unit.</p> <p>Findings include:</p>	F000323	F 323 Currently, Resident #60 is able to safely use any toilet riser in the facility as they have all been replaced and are securely anchored. Any resident who uses a toilet riser in the facility had the potential to be affected by this finding. The Maintenance Supervisor will check all of the facility toilet risers in the facility weekly x 4 weeks then monthly ongoing for a minimum of 6 months, as part of the Preventive Maintenance Program. Any concerns will be	03/25/2015			

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	<p>Resident #60's clinical record was reviewed on 2/19/15 at 9:35 a.m. Resident #60's diagnoses included, but were not limited to, syncope, Frederick's ataxia, anxiety and depression.</p> <p>A Nursing Progress Note dated 1/31/15, indicated the following: "Heard someone say help. Went to shower room next to nurses station where res [Resident #60] had went [sic], to see if it was her saying something. Upon entering noticed res on floor sitting on buttocks facing commode smiling. Asked res if she hurt anywhere and she stated no. Assessed skin and found 0 injuries, obtained vitals. Asked res if she had hit her head and res stated, 'No I just hit my butt.' Res stated she was trying to get off commode when the arms on commode moved and she fell on her butt, but she did not hit her head when asked what happened. Assessed skin, took vitals, assessed for pain, interviewed res. Helped res back into w/c [wheelchair], started neuros (neurological checks), placed pressure alarm in w/c, notified MD (physician)."</p> <p>A nursing order dated 1/31/15, at 4:15 a.m., indicated an alarm was to be placed in Resident #60's wheelchair due to recent fall.</p> <p>A Fall Investigation Note dated 1/31/15,</p>		<p>repaired/replaced upon discovery. The Maintenance Supervisor will keep a record of these checks as well as retaining all requests/repairs for reference.</p> <p>At an inservice for all staff held on 3/11/2015 and 3/12/2015, staff was reinserviced as to the process for making a request to the maintenance department for a repair or replacement. Also, staff was reminded to immediately report any concern which they feel could lead to an accident or injury if not repaired right away in an effort to promote a safe environment for the residents. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as appropriate. At the monthly QA meeting the monitoring of the toilet seat risers as well as the requests for repairs/replacements from the previous month will be reviewed. Any concerns will be addressed by the Administrator. If necessary, an Action Plan will be written by the QA Committee and monitored by the Administrator until resolved.</p>		

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	<p>indicated the wheelchair wheels were locked and Resident #60 was wearing the appropriate footwear.</p> <p>An IDT (Interdisciplinary Team) Note dated 2/2/15, indicated the following: "Pain assessment completed at time of fall, no c/o [complaints of] pain. Res interventions at this time, pressure alarm placed in wheelchair. Environmental review of shower room."</p> <p>During a tour of the 300/400 hall shower room on 2/19/15 at 3:53 p.m., the Administrator and the Maintenance Manager verbally acknowledged the toilet risers were wobbly and unsteady. The Administrator indicated the corporation was looking into remodeling the shower room on the 300/400 hall and the shower room on the Hope Springs Unit. The Administrator also indicated the toilet risers should have been replaced after the IDT did an environmental review of the shower room for the 300/400 hall. The Administrator stated there was no documentation of the decision to replace the the toilet risers but it should have been followed up on after the meeting. "I know we decided to have them replaced but didn't do a follow up." The Maintenance Manager indicated he did not keep a log of repairs nor did he keep repair tickets after a request was</p>						

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F000329 SS=E	<p>filled. "Once I finish with a ticket, I throw it away. I don't keep it".</p> <p>During a tour of the Hope Springs locked unit shower room on 2/19/15, at 4:14 p.m., the toilet risers were found to be wobbly and unsteady. The Administrator indicated the toilet risers would be replaced that day.</p> <p>During a tour of the shower room on each unit on 2/20/15, at 8:00 a.m., the toilet risers had been replaced with new steady risers.</p> <p>3.1-45(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and</p>			

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	<p>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 residents who received psychopharmacological medications had identified and behavioral indicators for use, gradual dose reductions or a statement of contraindication and the facility failed to ensure a resident who was prescribed diuretic medications had weight monitoring as ordered to ensure medication effectiveness for 4 of 5 residents reviewed for drug regimen review (Residents #61, #45, #11 and #34).</p> <p>Findings include:</p> <p>1. Resident #45's clinical record was reviewed on 2/19/15 at 10:01 a.m. Resident #45's current diagnoses included, but were not limited to, anxiety, depression and dementia with behavioral disturbances.</p> <p>Resident #45 had a current, 2/10/15, physician's orders for the following psychoactive medications:</p> <p>a. Sertraline 100 mg (an antidepressant</p>	F000329	F 329 Currently, Resident #45's care plan includes her behavior indicators to support the use of the related drugs for treatment of behaviors. Her behaviors are/will be documented. The side effects from these types of drugs are/will be documented should they exhibit. Also, a new behavior assessment has been done to include comments/plan to address her sleep patterns. Where to find resident specific approaches to Resident #45's behavior(s) are readily available to the CNA staff. Resident #61's record now includes a statement by the physician as to the rationale supporting the clinical contraindication for a gradual dose reduction of Zyprexa at this time. Resident #34's record now includes a statement by the physician as to the rationale supporting the clinical contraindication for a gradual dose reduction of Depakote at this time. Resident #11 is currently being weighed daily and this is being documented. The physician is notified as per policy and order. There is a policy in place for daily weights. Any resident who receives	03/25/2015			

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	<p>medication) - one tablet, one time daily. This order originated 2/13/13.</p> <p>b. Clonazepam 0.5 mg (an antianxiety medication) - one tablet daily at bedtime. This order originated 12/18/14.</p> <p>c. Quetiapine 25 mg ( an antipsychotic medication) - 1 and 1/2 tablets (37.5 mg) daily at bedtime. This order originated 6/28/14.</p> <p>d. Trazadone 150 mg (an antidepressant also used as a sleep aid) - 1/2 tablet (75 mg) daily at bed time for insomnia.</p> <p>Resident #45's, 8/11/11, admission orders indicated she had received the antianxiety medication, clonazepam, the antidepressant medication, Sertraline, and the antipsychotic medication, quetiapine at the time of her admission. The record indicated she had taken some form of antipsychotic, antidepressant and antianxiety medications daily since admission.</p> <p>Resident #45 had a current, 11/19/14, quarterly, Minimum Data Set assessment (MDS) which indicated the resident was cognitively impaired, required assistance and cueing for decision making and displayed no maladaptive behaviors.</p>		<p>psychopharmacological meds to treat behaviors or residents who are to be weighed daily have the potential to be affected by this finding. All residents on the afore mentioned drugs have had their records reviewed to see that the following is in place: "Behavior Management Psychotropic Medication" A. An acceptable supporting diagnosis for use of the ordered psychopharmacological drug B. Monitoring/tracking of behaviors C. Monitoring/tracking side effects of these drugs D. Documentation/Care planning E. Attempts at gradual dose reduction unless clinically contraindicated Further, all residents who are to be weighed daily have been "listed" and they are/will be weighed daily with notification to the physician as indicated. The DON/Designee along with the SSD will monitor residents who receive psychopharmacological meds at the monthly Behavior Management meetings to verify that these residents have the afore mentioned requirements implemented. Additionally, as orders are received for psychopharmacological meds these residents will be added to the targeted list of residents (who receive these meds) which is kept by the DON/Designee and SSD for monitoring and possible reduction. This monitoring will be ongoing indefinitely. Also, the</p>		

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	<p>Resident #45 had a current, 11/19/14, care plan problem/need regarding "insomnia/sleeps much during day."</p> <p>Resident #45 had a current, 11/19/14, care plan problem/need regarding the resident's desire to stay in bed or in her room the majority of the time.</p> <p>Resident #45's record lacked the following:</p> <ul style="list-style-type: none"> <li>a. Identified behavioral symptoms (behavioral indicators) being treated by Clonazepam, Sertraline or Quetiapine.</li> <li>b. A care plan related to the behavioral symptoms being treated by Clonazepam, Sertraline or Quetiapine.</li> <li>c. Any documented maladaptive behaviors in February or January 2015 or December and November 2014.</li> <li>d. An assessment of Resident #45's day time sleeping in relation to her night time insomnia medication. The number of hours slept during the day and the perceived need for night time sleeping.</li> </ul> <p>Resident #45 was resting or sleeping in bed during observations on 2/19/15 at 1:28 p.m., 2/19/15 at 2:00 p.m., 2/20/15 at 11:00 a.m., and 2/20/15 at 11:33 a.m.</p> <p>During a 2/20/15, 12:13 p.m., interview, LPN #2 indicated, Resident #45 had some periods of anxiety when the</p>		<p>DON/Designee will monitor to see that daily weights are being obtained/documented/followed through on as appropriate/ daily 5 days weekly until 4 consecutive weeks of zero negative findings are achieved, for at least 6 months, and then monitoring will occur weekly randomly ongoing. Any missed weights will be obtained as discovered. At the daily CQI meetings residents who have had a behavior on the 24 Hour Report or the shift to shift report or who have received a new order for a psychopharmacological med will have the behavior discussed to ensure that it was properly addressed. Further, any resident who receives an order for this type of medication will be placed on the list of targeted residents kept by the DON/Designee and SSD for tracking and monitoring of behaviors/side effects/gradual dose reduction attempts (unless clinically contraindicated) documentation/care planning Also, residents who receive orders for daily weights will be added to that targeted list of residents kept by the DON/Designee for appropriate monitoring/follow through. At an inservice held on 3/11/2015 and 3/12/2015 , for nursing staff the following was reviewed:</p> <ul style="list-style-type: none"> <li>Behavior Management</li> <li>Psychotropic Medication 1.</li> <li>Supporting Diagnosis- Validation of order 2. Behavior Tracking</li> </ul>				

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	<p>resident stated she felt funny and appeared anxious by her words and movements. LPN #2 also indicated Resident #45 slept during the day almost every day and then would have periods of insomnia at night. Resident #45 would often sit by the nurses station at night if she could not sleep. Resident #45 did not make statements of distress regarding her inability to sleep at night.</p> <p>During a 2/20/15, 11:52 a.m. interview, the Assistant Director of Nursing (ADON) indicated she was unaware of Resident #45 displaying any behaviors.</p> <p>During a 2/23/15, 10:22 a.m., interview, CNA #3 indicated she regularly provided care for Resident #45. CNA #3 indicated Resident #45 mostly slept during the day. She indicated Resident #45 did not display maladaptive behaviors when she cared for her. CNA #3 also indicated there was no place to find resident specific approaches to behaviors. CNA #3 indicated staff receive verbal information about residents when they are admitted and staff talk to each other to ensure everyone knows what each resident needs.</p> <p>The Director of Nursing (DON) and Social Services Designee (SSD) on 2/23/15, 12:49 p.m., were interviewed</p>		<p>3. Signs/Symptoms of side effects from these drugs; tracking/ monitoring 4. Gradual dose reduction (unless clinically contraindicated) 5. Documentation/care planning DAILY WEIGHTS 1. Timely 2. Accurate 3. Follow through/notifications as indicated 4. SWAT meeting (Skin Weigh Assessment Team) 5. Documentation/care planning Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings the minutes (discussion) of the DON/Designee and the SSD monthly Behavior Monitoring meeting will be reviewed. Any patterns will be discussed. If necessary, an Action Plan will be written by the QA Committee. The plan will be monitored by the Administrator until resolution.</p>				

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	<p>regarding Resident #45 and behavioral symptoms being treated by the use of her four psychoactive medications and care plans related to these behaviors. There were also questions regarding Resident #45's sleeping pattern and the need for night time sleep and a sleep aid. Both staff members indicated the facility had recently identified a problem with psychopharmacological medications (medications to aid mood behavior and mental illness) and the components of a properly functioning psychoactive medication program. The facility had not yet put a plan in place to ensure each medication had a behavioral symptom and all behavioral symptoms were care planned. Both staff members indicated they would review Resident #45's record to see if she had the required documentation.</p> <p>On 2/23/15 at 1:15 p.m., both the DON and SSD indicated Resident #45's record lacked behavioral indicators for the use of her psychopharmacological medications. They also indicated Resident #45 had not been assessed for day sleeping and the use of a night sleep aid. They both indicated Resident #45 was an example of the problem the facility had identified with psychopharmacological medications and Resident #45 would be included in their</p>						

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	<p>corrective actions.</p> <p>2. Resident #61 was observed sitting calmly in his wheelchair on the following dates and times:</p> <p>2/19/15 from 10:03 a.m. to 10:33 a.m., in a group activity in Hope Spring's lounge.</p> <p>2/19/15 at 12:46 p.m., in Hope Spring's dining room.</p> <p>2/20/15 at 8:32 a.m., in Hope Spring's dining room.</p> <p>2/23/15 at 10:47 a.m., in a group activity in Hope Spring's lounge.</p> <p>Resident #61's clinical record was reviewed on 2/19/2015 at 10:04 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, delusional disorder, and major neuro cognitive disorder.</p> <p>The resident's current Physician's Orders were signed by the physician on 2/4/15. The resident had orders for Zyprexa [an antipsychotic medication] 10 mg every evening and divalproex sodium [a mood stabilizer] 125 mg 4 capsules (500 mg) three times a day.</p> <p>The resident had a 2/3/15, Pharmacy Recommendation related to Zyprexa 10 mg daily and Depakote [divalproex sodium] 500 mg three times a day. The recommendation was to consider a gradual dose reduction and if a reduction</p>						

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	<p>was not appropriate to ensure the chart contained proper documentation to indicate a gradual dose reduction was contraindicated. The physician indicated a reduction would be considered in the future. The record lacked a statement of contraindication which included a risk benefits analysis for the medications or other rationale for continuing the medications.</p> <p>During an interview with LPN #4 on 2/20/15 at 11:15 a.m., she indicated the facility's documentation system alerts Social Services when behaviors are documented in the progress notes.</p> <p>During an interview with the Social Service Designee on 2/20/15 at 12:25 p.m., she indicated she was new to the position and she had no documented behaviors for the resident.</p> <p>During an interview with the Social Service Designee on 2/20/2015 at 2:43 p.m., she indicated the Director of Nursing told her the doctor felt the resident was stable and did not want to change the resident's medications at the time of the pharmacy recommendation.</p> <p>3. The clinical record for Resident #34 was reviewed on 2/20/15 at 12:03 p.m. Current diagnoses included, but were not limited to, dementia with behavioral</p>						

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	<p>disturbances, depressive disorder, excitive type psychosis, cognitive communication deficit and atypical mania with psychosis.</p> <p>The resident was currently receiving the following medication, three times daily Depakote (Mood stabilizer) 500 milligrams ordered on 7/7/14.</p> <p>The chart indicated a pharmacy recommendation printed on 2/3/15 for a GDR (Gradual Dose Reduction) for Depakote 500 milligrams TID (three times a day) for the diagnosis of dementia with behaviors. The recommendation also indicated: "Please consider a gradual dose reduction. If a reduction is not appropriate at this time, please ensure the chart contains the proper documentation to indicate that a GDR is contraindicated."</p> <p>The Physician/Prescriber Response to the pharmacy recommendation indicated the following: "Will consider in the near future." No statement of contraindication which included a risk benefit analysis was provided.</p> <p>No further documentation was provided by the facility at the time of exit on 2/23/15.</p>			

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	<p>Review of the current, undated facility policy, titled "BEHAVIOR MANAGEMENT PSYCHOTROPIC MEDICATION PROTOCOL", provided by the Director of Nursing on 2/23/15 at 9:00 a.m., included but was not limited to, the following:</p> <p>"POLICY: Residents with behaviors that are displayed routinely, that effect the resident's psychosocial well-being or that of other residents, or behaviors that can have potential for harm to self or others will be assessed with the development of a behavior program.... ...that these behaviors were persistent and were not caused by preventable reasons.... ...Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications and will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs.... ...PROCEDURE: There will be an established Behavior Management/Psychotropic Medication Review Committee that will meet routinely to review all residents mentioned above and others as the Committee deems appropriate...."</p> <p>4. The clinical record for Resident #11 was reviewed on 2/19/15 at 9:57 a.m. Diagnoses for Resident #11 included, but</p>			

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	<p>were not limited to, insomnia, congestive heart failure, chronic obstructive pulmonary disease, edema, and atrial fibrillation.</p> <p>Resident #11 had the current physician orders for the following:</p> <p>a. Furosemide (a diuretic medication) 40 milligrams (mg) take 1 tablet by mouth once daily. This order originated 12/24/14.</p> <p>b. Check and record weight daily. Call the physician for a weight gain of 3 pounds overnight or 5 pounds in 1 week. This order originated 1/8/15.</p> <p>A health care plan, dated 10/15/14, indicated Resident #11 had a problem listed as, the resident is at risk of dehydration related to diuretic therapy. Interventions for this problem included, but were not limited to, monitor weight and vital signs, observe and report signs of increased edema, and report any changes to the physician.</p> <p>A health care plan, dated 7/12/13 and continued to be applicable on 1/2/15, indicated Resident #11 had a problem listed as, the resident has a diagnosis of congestive heart failure. An intervention for this problem was to observe the</p>				

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	<p>resident for shortness of breath and edema.</p> <p>A health care plan, dated 11/19/13 and continued to be applicable on 1/2/15, indicated Resident #11 had a problem listed as, the resident has a diagnosis of chronic obstructive pulmonary disease. Interventions for this problem included, but were not limited to, notify physician and family of changes in condition.</p> <p>Review of the weights in the clinical record for Resident #11 from 1/8/15 to 2/22/15, indicated the clinical record lacked daily weights for 1/20/15, 1/22/15, 1/23/15, 1/27/15, 1/28/15, 1/29/15, 1/31/15, 2/2/15, 2/5/15, 2/9/15, 2/13/15, 2/16/15, and 2/18/15. The nurses notes indicated the daily weight for 2/5/15 was 173.4 pounds, an overnight weight gain of 5.4 pounds from 168 pounds on 2/4/15. The physician was notified of the 2/5/15 weight gain for Resident #11. The clinical record for Resident #11 lacked documented daily weights for 12 days, from 1/8/15 to 2/22/15.</p> <p>During an interview with the Director of Nursing (DON) on 2/23/15 at 9:31 a.m., additional information was requested related to the missing weights for 1/20/15, 1/22/15, 1/23/15, 1/27/15, 1/28/15, 1/29/15, 1/31/15, 2/2/15, 2/9/15,</p>						

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F000364 SS=E	<p>2/13/15, 2/16/15, and 2/18/15 for Resident #11.</p> <p>During an interview with the DON on 2/23/15 at 10:25 a.m., she indicated she had no other information to provide related to the missing daily weights for Resident #11.</p> <p>During an interview with the DON on 2/23/15 at 11:17 a.m., she provided the only policy related to weight assessment. She indicated the policy "doesn't really address daily weights."</p> <p>The current facility policy, dated 2010, titled "Weight Assessment and Intervention", provided by the Director of Nursing on 2/23/15 at 11:17 a.m., did not address daily weights.</p> <p>3.1-48(a)(3) 3.1-48(a)(6) 3.1-48(b)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to serve</p>	F000364	F 364 Currently, Residents 42, 13, 10, 11, 53, 60 and 46, 47	03/25/2015			

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	<p>food at a palatable temperature for 9 of 15 residents interviewed regarding food palatability (Residents #42, #13, #10, #11, #53, #60, #46, #47 and #88).</p> <p>Findings include:</p> <p>During 2/18/15 and 2/19/15 interviews, with residents who were determined to be reliable during the stage one survey process, 9 of 15 residents interviewed indicated the food was cold and not served at a palatable temperature as follows:</p> <p>Resident #42 on 2/18/15 at 2:48 p.m. Resident #13 on 2/18/15 at 2:37 p.m. Resident #10 on 2/18/15 at 9:41 a.m. Resident #11 on 2/18/15 at 11:10 a.m. Resident #53 on 2/18/15 at 9:20 a.m. Resident #60 on 2/18/15 at 2:13 p.m. Resident #46 on 2/18/15 at 1:44 p.m. Resident #47 on 2/18/15 at 12:59 p.m. Resident #88 on 2/18/15 at 1:32 p.m.</p> <p>Review of Resident Council Minutes for 9/2014 through 1/2015 contained statements of concern regarding food dissatisfaction due to cold temperatures on 1/29/15, 12/26/14 and 10/30/14 (3 of 5 months).</p> <p>Review of Food Council Minutes for 9/2014 through 1/2015 contained</p>		<p>and 88 are satisfied with the temperatures and palatability of their meals. All residents who consume meals prepared in the dietary department of the facility have the potential to be affected by this finding. New dietary equipment including covered carts (received) and plate warmers (on order) have been/will be put into service to enhance maintaining of food temps. Additionally, cart/tray deliveries have been reviewed and time efficient changes to the delivery system have been made. Food is being "temped" before it leaves the dietary department and a test tray (last tray delivered on a unit) is being "temped" daily by the Dietary Manager/Designee 5 days weekly at various meal times/areas to ensure that temps are maintained. Additionally, at these monitorings, the tray delivery time will be observed. Any concerns will be addressed as discovered. Monitoring will continue for a minimum of 6 months, and then until 4 consecutive weeks of zero negative findings are achieved. Afterwards, monitoring will occur randomly weekly ongoing. Further, the 9 residents listed are interviewed weekly by the Dietary Manager/Designee to be sure they are satisfied with their meals. Any concerns will be addressed as discovered. The interviews will coincide with the monitoring. At an inservice held</p>				

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	<p>statements of concern regarding concerns with food palatability and cold food temperatures on 12/16/14, 11/26/14 and 10/30/14 (3 of 5 months).</p> <p>During a 2/20/15, 9:59 a.m., interview, the Food Services Supervisor indicated she had made changes to the food service process in order to ensure food temperatures were hot and palatable. She also indicated she had not done any formal audits to ensure the changes had been effective. She stated she had periodically asked residents how the food was and if it was warm enough. She indicated the facility was making additional changes to improve food temperatures such as the purchase of additional covered food carts.</p> <p>During a 2/20/15, 8:38 a.m., meal service observation, the food cart arrived at the 300/400 Station at 8:38 a.m. The meals were delivered to the resident's on the 400 hall first and took 10 minutes to be delivered to that hall. At 8:48 a.m., the cart was then pushed to the 300 hall and meals were served to that unit. The last tray was served on the 300 hall at 8:57 a.m.(a period of 19 minutes).</p> <p>During a 2/20/15, lunch meal observation the following occurred:</p>		<p>on 3/11/15 and 3/12/15, for nursing staff and dietary staff the importance of meals being served timely and food being served at acceptable temperatures with palatability was reviewed. Points covered were: Dietary A. Food temps-range/"logs" B. How to "maintain" temps C. Test tray temp log (DM or Designee) Nursing A. How to "maintain" temps B. Timely delivery of trays C. What to do if a resident complains of a food temp Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the food temps monitoring and timely tray delivery will be reviewed. Any concerns will have been addressed as discovered. However, any patterns identified may be further addressed by an Action Plan written by the QA Committee and monitored weekly by the Administrator until resolved.</p>				

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	<p>On 2/20/15 at 11:30 a.m., the dietary personnel began to place food on plates and placed the plates in an insulated container. The plates had been warmed in a plate warmer. Divided plastic plates used to serve pureed and mechanical soft diets could not be placed in the plate warmer and were not warm when the food was placed on them. The insulated container did not have a heated insert. Divided plates did not have any insulation beneath the plate and were covered with an insulated lid. The food cart was filled with multiple meals to be taken to the unit to be served. The last plate was placed on the cart and the cart door was closed at 11:45 a.m. (a period of 15 minutes from start to finish).</p> <p>The food cart was then taken to the Hope Springs unit for service at 11:47 a.m. The final plate was served on the unit at 12:06 p.m. (a period of 19 minutes after the tray arrived on the unit). The process of putting the plates on the cart, transporting the plates to the unit and serving them to residents could result in a period of 36 minutes (11:30 a.m. to 12:06 p.m.).</p> <p>During a 2/23/15, 2:30 p.m., interview, the Administrator indicated the facility had been monitoring food temperatures in the kitchen as the food was being</p>						

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F000431 SS=D	<p>placed on the plate. She indicated the facility had not monitored/tested food temperatures at the point of services. She indicated she had not realized plates could be on the food cart for such a long period of time before they were served to the residents. She additionally indicated, the facility was considering heated inserts for the insulated covers but were still in the process of determining what insert would work best with the insulated containers.</p> <p>3.1-21(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and</p>				

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	<p>biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with accepted professional principles, and recognized the appropriate date of expiration. This deficient practice had the potential to effect 3 residents identified during medication storage review. (Resident #35, Resident # 67 and Resident #57).</p> <p>Findings include:</p> <p>During the 300/400 hall medication storage observation on 2/23/14 at 9:05 a.m., with the Assistant Director of Nursing (ADON), the following concern was noted:</p> <p>1. One opened bottle of Dankin's Solution ( an antiseptic solution) with a receive date of 9/12/14 was noted with no open date. (Resident #35)</p>	F000431	F 431 Currently, Residents 35, 57 and 67 have any meds or biologicals used in their care and treatment labeled in accordance with accepted professional principles including dates of expiration. Currently, all meds and/or biologicals are properly labeled per cart audits. Any resident who receives medications or biologicals in the facility have the potential to be affected by this finding. The DON/Designee will go through each med and treatment cart once weekly to ensure that all meds and biologicals are labeled properly including expiration dates. Any preparation found not to have an acceptable label will be destroyed and reordered as necessary. This cart monitoring will continue for a minimum of 6 months, and then until 4 consecutive weeks of zero negative findings are achieved. Afterwards, random monthly	03/25/2015			

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	<p>During the Hope Springs Unit medication storage observation on 2/23/14 at 10:38 a.m., with the ADON, the following concern were noted:</p> <p>1. Two Lantus Insulin pens (for Diabetes Mellitus) with open dates of 1/18/15, a period of 36 days. (Resident # 67 and Resident #57)</p> <p>During an interview on 2/23/15 at 10:38 a.m., the ADON indicated the opened Dankin's solution bottle should have had an open date. The ADON also indicated the Lantus Insulin pens should have been removed from the medication cart and discarded due to being past the after open expiration time of 28 days.</p> <p>Review of the current facility policy, dated June 19, 2012, titled "MEDICATION STORAGE IN THE FACILITY", provided by the Administrator on 2/23/15 at 2:30 p.m., included, but was not limited to, the following:</p> <p>"Policy: Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to</p>		<p>monitoring will occur. An inservice was held for nursing staff who administer meds on 3/11/15 and 3/12/15 at which time the entire policy on Medication Storage in the Facility was reviewed with particular emphasis on labeling/expiration dates/what to do with improperly labeled or expired meds and/or biologicals. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as appropriate. At the monthly QA meeting the results of the med cart monitoring will be reviewed. Any concerns will have been addressed as discovered. Any patterns identified will be addressed via an Action Plan written by the QA Committee and monitored weekly by the Administrator as indicated.</p>				

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F000520 SS=E	<p>administer medications...."</p> <p>Review of the "Nursing 2014 Drug Handbook 34th Edition" states: "...Lantus...Discard opened vials or cartridge system after 28 days whether refrigerated or not..."</p> <p>3.1-25(o)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility's Quality</p>	F000520	F 520 The facility's Quality Assurance Committee has	03/25/2015			

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	<p>Assurance Committee failed to implement a systematic action plan to ensure palatable food temperatures for 9 of 15 residents interviewed. (Resident #'s 42, 13, 10, 11, 15, 60, 46, 47, 88)</p> <p>Findings include:</p> <p>During 2/18/15 and 2/19/15 interviews, with residents who were determined to be interviewable during the stage one survey process, 9 of 15 residents interviewed indicated the food was cold and not served at a palatable temperature.</p> <p>During a 2/20/15, 9:59 a.m., interview, the Food Services Supervisor indicated she had made changes to the food service process in order to ensure food temperatures were hot and palatable. She also indicated she had not done any formal audits to ensure the changes had been effective. She stated she had periodically asked residents how the food was and if it was warm enough. She indicated the facility was making additional changes to improve food temperatures such as the purchase of additional covered food carts.</p> <p>During an interview with the Administrator on 2/23/15 at 1:42 p.m., she indicated the facility had done random audits for food temperatures.</p>		<p>implemented a plan to ensure that foods are served at a palatable temperature for residents including those cited in the finding. These residents are currently satisfied with the food temps as being served. The remainder of the response to F 520 is contained in the response to F 364 except to state that going forward a member of the corporate staff will monitor the minutes of the monthly QA meetings for a minimum of 6 months to ensure that concerns brought to the QA Committee as a result of a Resident Council concern or by a specific audit process has either been resolved or has an Action Plan written and followed through to an acceptable resolution. This monitoring will continue until 4 consecutive months of zero negative findings are achieved. Afterwards, random monitoring will occur quarterly on going. The Administrator will be part of this monitoring.</p>	

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	<p>She indicated the QAA Committee felt the cold food complaints came from the same group of residents each month in Resident Council and the corrective action had been to heat their food hotter than the food served to the other residents.</p> <p>During a 2/23/15, 2:30 p.m., interview, the Administrator indicated the facility had been monitoring food temperatures in the kitchen as the food was being placed on the plate. She indicated the facility had not monitored/tested food temperatures at the point of services. She indicated she had not realized plates could be on the food cart for such a long period of time before they were served to the residents. She additionally indicated, the facility was considering heated inserts for the insulated covers but were still in the process of determining what insert would work best with the insulated containers.</p> <p>This deficiency was cited on 3/3/14, and the facility failed to implement an action plan to correct this deficiency.</p> <p>3.1-52(b)(2)</p>			