

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
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NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 3, 4, 5, 8, 9, 10, & 11, 2016</p> <p>Facility number: 000158 Provider number: 155255 AIM number: 100291490</p> <p>Census bed type: SNF: 26 SNF/NF: 54 NCC: 3 Total: 83</p> <p>Census payor type: Medicare: 13 Medicaid: 34 Other: 36 Total: 83</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on February 16, 2016 by 17934.</p>	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0224 SS=D Bldg. 00	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication was not removed and misappropriated from one resident's (Resident #61) supply and used for another resident (Resident #88) during a medication pass observed for 1 of 10 residents.</p> <p>Findings include:</p> <p>During an observation on 2-8-2016 at 1:07 p.m., LPN #20 (Licensed Practical Nurse) prepared the breathing treatment from the medication cart for Resident #88. LPN #20 was observed to obtain a plastic tube of liquid from a box in the bottom drawer of the medication cart. LPN #20 was asked to provide the box with the prescription for Resident #88's treatment. LPN #20 provided a box with a prescription label for Resident #88 which indicated "...albuterol Neb 0.083%... use 1 vial via nebulizer every 6</p>	F 0224	<p>It is the policy of the facility to ensure that policies are in place and are being followed to ensure that mistreatment, neglect, abuse and misappropriation of resident property is prohibited. Resident #61 has had the borrowed medication that was removed from Resident #61's supply replaced at the expense of the facility. Further, Resident #88 has an adequate supply of all of their ordered meds maintained. Should a shortage occur, the local back up pharmacy will provide any meds not timely available from the facility's contracted pharmacy. Any resident who received ordered meds has the potential to be affected by this finding. All med carts and med storage areas (such as med room refrigerators) were audited to see that all ordered meds were available to all residents for timely administration. Any found to be running in short supply were obtained. Going forward, the DON/Designee will monitor all</p>	03/12/2016

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	<p>hours as needed...." LPN #20 was observed to provide the breathing treatment as she opened the clear plastic tube, instilled the liquid into the nebulizer chamber and proceeded with the treatment.</p> <p>A review of Resident #88's physician orders and MAR (Medication Administration Record) on 2-8-2016 at 3:10 p.m., indicated the "...Duoneb Solution 0.5-2.5 (3) MG/3 ML (Milligram/Millimeter)...inhale orally three times a day...." was initialed by LPN #20 for 1:00 p.m. on the MAR. An observation of the MAR indicated no albuterol sulfate was initialed as given to Resident #88 at anytime from 2-1-2016 through 2-8-2016.</p> <p>An interview with LPN #20 on 2-8-2016 at 3:25 p.m., indicated she took a Duoneb from Resident #61's Duoneb box because Resident #88 did not have anymore of the Duoneb medication. LPN #20 indicated during the medication pass she showed the albuterol sulfate box with Resident #88's name on it as what she used for the breathing treatment. LPN #20 indicated she opted to use another resident's Duoneb because Resident #88 needed it. She also indicated the pharmacy did not provide prescriptions on Sundays and it was not in the EDK. (Emergency Drug</p>		<p>med carts or med storage areas (such as med room refrigerators) 3 times weekly to ensure that all ordered meds are on hand in an adequate supply to administer ordered doses timely. Further, insulins, eyedrops, inhalers, nasal sprays, multi-dose vials and over the counter meds will be monitored to see that they are properly labeled/dated and are not past either the expiration date for the product or the expiration as related to the date they were opened. Any concerns will be addressed as discovered. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, this monitoring will occur weekly for not less than 6 months to ensure on-going compliance. After that, random monitoring will occur. At an in-service held for all nursing staff who pass medications the following was reviewed:</p> <p>A. Medication Administration-Policy & Procedure B. Abuse Policy and Resident Rights with emphasis on misappropriation of resident property C. Why medications cannot be "borrowed" D. What to do if a med supply is running low E. Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly Quality Assurance meetings the results of the</p>				

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	<p>Kit)</p> <p>An interview with the DON (Director of Nursing) on 2-9-2016 at 8:28 a.m., indicated when a resident does not have a medication in the medication cart and the medication was due to be given, she expected staff to call pharmacy and get the medication stat (as soon as possible) from a local pharmacy.</p> <p>A current policy "Ordering Medications" dated 6-19-2012 and provided by the DON on 2-9-2016 at 9:50 a.m., indicated "...medication and related products are ordered from (company name) pharmacy on timely basis...reorder medication three days in advance of need to assure an adequate supply is on hand...always use the convenience or emergency box supply before requesting a stat...."</p> <p>A current policy "Abuse Prohibition" dated 7-1-11 and provided by the Administrator on 2-9-2016 at 9:05 a.m., indicated "...the facility will not condone abuse of any type by anyone including staff members...misappropriation of Resident Property...the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent...."</p>		<p>medication monitoring will be reviewed. Any concerns will have been addressed as found. However, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be reviewed weekly by the Administrator weekly until resolved.</p>	

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F 0225 SS=D Bldg. 00	<p>3-1.28(a)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his</p>				

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	<p>designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>A. Based on interview and record review the facility failed to report the fall from a Hoyer lift of 1 dependent resident (Resident #10) with a resultant laceration to her head requiring staples in the Emergency Room.</p> <p>B. Based on interview and record review, the facility failed to complete a thorough investigation of a CNA (Certified Nursing Assistant) who was reported to have spoken offensively to a resident. The facility also failed to report the incident of the allegation of abuse to the Indiana State Department of Health. (Resident #51)</p> <p>Findings include:</p> <p>A. Review of the clinical record for Resident #10 on 2/8/16 at 8:30 a.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's disease, muscle weakness, dementia, contracture, abnormal posture, and unspecified dementia with behavioral disturbance.</p>	F 0225	<p>It is the policy of the facility to ensure that all reporting and notifications take place involving any accidents or violations that meet reporting and notification criteria as per state regulations. The incident involving Resident #10 that occurred on 1/7/16 has been reported to the ISDH. The incident involving alleged verbal abuse towards Resident #51 by staff member CNA #31 has been reported to the ISDH. CNA #31 has been 1:1 in-serviced on the Abuse Policy as well as Resident Rights and Dignity. Any resident who resides in the facility has the potential to be affected by this finding. A 60 day "look back" audit was conducted of all unusual documented incidents to ensure that any that meet reportable criteria were reported. If any were found not to be reported, they were reported. Further, any incidents categorized as customer service concerns were reviewed to see if they met reportable criteria as an alleged abuse. If any were found not to be reported, they were reported. Going forward, at the morning CQI meetings, any incident that appears on the 24 hour report or</p>	03/12/2016

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	<p>A physician's order for Resident #10, dated 10/12/15, indicated may use Hoyer lift for transfers.</p> <p>A Progress Note for Resident #10, dated 1/7/16 at 8:08 p.m., indicated she was being Hoyer lifted during a transfer and the Hoyer lift pad gave out. The note also indicated the resident slipped to the floor bumping the back of her head on the floor. The note further indicated there was copious amounts of bleeding noted, with a 3.5 cm (centimeter) x (times) 5 cm cut with a 6 cm bump. A new order was received to send the resident to the hospital.</p> <p>A hospital Emergency Room report for Resident #10, dated 1/7/16, indicated the resident was dropped from the Hoyer lift at the nursing home. The report also indicated the staff denied any loss of consciousness. A CT (Computerized Tomography) scan of her head indicated a significant scalp contusion along the high midline parietal scalp. The report further indicated the laceration to the back of her head was repaired with staples.</p> <p>A Progress Note for Resident #10, dated 1/7/16 at 11:50 p.m., indicated she returned to the facility from the hospital.</p>		<p>any incident that requires further investigation that has occurred since the previous CQI meeting will be reviewed to see if it meets reportable criteria for the ISDH. If it does, timely reporting and follow up will be validated and any further needed action will be taken. This monitoring of follow up on these events will be the responsibility of the Administrator and will be ongoing. A Regional team member reviewed the reportable criteria as set forth by the ISDH with the Administrator and DON. Also, the difference between a customer service issue and an alleged abuse issue was discussed and defined. An all staff in-service is being held March 2nd at which time the following will be reviewed:</p> <p>A. Abuse Policy—Reportable Criteria B. Resident Rights C. What to do if you become aware of an alleged abuse D. Customer Service—defined E. Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meeting the incidents that were reported as well as the customer service issues will be reviewed to see that all appropriate actions and follow up took place. Any concerns will be addressed. If any patterns emerge, an Action Plan will be written by the committee to</p>				

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	<p>The note also indicated there was a small amount of serosanguineous (yellow with small amounts of blood) drainage noted, swelling around the perimeter of the laceration repair, and 7 staples intact at 5 cm long.</p> <p>A Certified Nursing Assistant (CNA) Assignment Sheet for Resident #10, provided by the Director of Nursing on 2/9/16 at 9:51 a.m., indicated she was dependent on 2 staff with the Hoyer lift for transfers.</p> <p>The Administrator and Director of Nursing were interviewed on 2/9/16 at 10:05 a.m. During the interview they indicated only 1 staff transferred Resident #10 when she fell from the Hoyer lift. They also indicated the fall was not reported to the Indiana State Department of Health (ISDH) by the previous Administrator.</p> <p>B. On 2/10/16 at 11:42 p.m., LPN (Licensed Practical Nurse)#30 was interviewed. She indicated there had been an incident recently where a staff member was overheard speaking to a resident in a manner that could have been perceived as offensive to the resident. She indicated "no matter what the situation, you have to act on them" (allegations or actual situations of abuse). She indicated the</p>		address them. Any Action Plan will be monitored weekly by the Administrator until resolved.	

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	<p>resident involved in this incident was Resident #51.</p> <p>On 2/11/16 at 10:00 am., the Administrator provided a copy of the investigation of the allegation of abuse which involved Resident #51. The investigation included, but was not limited to, the following: "On 1/26/16, I received a phone call from LPN #30 on night shift stating CNA #31 was allegedly heard telling Resident #51 to be quiet when she had asked to be helped...I came in and spoke with Resident #51. Resident #51 did not remember anything. I spoke with CNA #31 at home and got a written statement from her. She stated on the phone and in person, Monday morning 1/28/16, that she went into Resident #51's room to help her and told her to (sic) she will help her get changed and to try to be quiet because it was the middle of the night. She stated she was not condescending in any way...We discussed customer service expectations on Monday 1/28. No allegations of abuse were presented..." This investigation was signed by the Administrator.</p> <p>The investigation also included a written statement from CNA #31. The written statement included, but was not limited to, the following: "...doing my bed check and Resident #51 was saying she was wet</p>			

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	<p>and I told her to hold on..."</p> <p>The investigation also included a written statement from LPN #30. The written statement included but was not limited to, the following: "Staff reported what he heard from another staff. I asked if he can write a statement about the incident, which he did..."</p> <p>Documentation was lacking in the investigation of the written statement of the staff member who reported the allegation of verbal abuse to LPN #30 on 1/26/16.</p> <p>On 2/11/16 at 10:49 a.m., the Administrator indicated she did not report the incident which involved Resident #51 to the state agency. She indicated she did not report this because when she talked to LPN #30 on 1/26/16, LPN #30 relayed to the Administrator, it was more of a customer service concern with CNA #31. The Administrator indicated she did not interview any residents other than Resident #51 on 1/26/16 or the next day. The Administrator indicated CNA #31 returned to work on 1/28/16.</p> <p>On 2/11/16 at 10:56 a.m., the Administrator was interviewed. She indicated as part of their investigation,</p>			

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	<p>other residents, employees and/or any witnesses would be interviewed. She indicated allegations should be reported to the state agency, "You report everything."</p> <p>On 2/11/16 at 11:22 a.m., the Administrator provided a current undated copy of "Abuse Prevention Program." This copy included, but was not limited to, the following: "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect...Upon learning of the report the Administrator...shall initiate an incident investigation...For any incident involving suspicion of abuse...the Administrator...will gather further facts prior to making a determination to conduct an abuse investigation...When an alleged or suspected case of abuse...is reported to the Administrator...will notify the following persons or agencies of such incident immediately...State Licensing and Certification Agency..."</p> <p>On 2/11/16 at 11:40 a.m., the Administrator was interviewed She indicated she should have reported the incident which involved Resident #51 to the state agency. She also indicated she should have interviewed additional residents to see if there were other</p>			

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	<p>concerns of verbal abuse by any staff.</p> <p>On 2/11/16 at 12:55 p.m., the Administrator was interviewed. She indicated the "he" referred to in LPN #30's statement was Laundry Staff #32. The Administrator indicated Laundry Staff #32 indicated as he passed by the Resident #51's room, he heard CNA #31 tell Resident #51 to be quiet. The Administrator indicated she did interview the laundry staff and requested a written statement from him but never got one.</p> <p>A current facility policy "Reportable Process to ISDH", dated 12/5/14 and provided by the Administrator on 2/9/16 at 11:16 a.m., indicated "...Reporting of incidents to ISDH are the responsibility of the administrator of the facility...Administrator or designee will report initial incident per ISDH Reportable Guidelines...It is the responsibility of the administrator to ensure all interventions in the reportable are completed and documented timely and accurately...The administrator is responsible for ensuring that the incident is thoroughly investigated...."</p> <p>3.1-28(c)</p>			

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>A. Based on interview and record review the facility failed to implement and follow their policy on reporting to the appropriate state agency the fall from a Hoyer lift of 1 dependent resident (Resident #10) with a resultant laceration to her head requiring staples in the Emergency Room.</p> <p>B. Based on interview and record review, the facility failed to follow their abuse program to complete a thorough investigation of a CNA (Certified Nursing Assistant) was reported to have spoken offensively to a resident. The facility also failed to follow their abuse program to report the incident of allegation of abuse to the Indiana State Department of Health. (Resident #51)</p> <p>Findings include:</p> <p>A. Review of the clinical record for Resident #10 on 2/8/16 at 8:30 a.m., indicated the following: diagnoses</p>	F 0226	<p>It is the policy of the facility to ensure that mistreatment, neglect, abuse and misappropriation of resident funds or property is prohibited. The incident involving Resident #10 that occurred on 1/7/16 has been reported to the ISDH. The incident involving alleged verbal abuse towards Resident #51 by staff member CNA #31 has been reported to the ISDH. CNA #31 has been 1:1 in-serviced on the Abuse Policy as well as Resident Rights and Dignity.</p> <p>Any resident who resides in the facility has the potential to be affected by this finding.</p> <p>A 60 day "look back" audit was conducted of all unusual documented</p>	03/12/2016

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	<p>included, but were not limited to, Alzheimer's disease, muscle weakness, dementia, contracture, abnormal posture, and unspecified dementia with behavioral disturbance.</p> <p>A physician's order for Resident #10, dated 10/12/15, indicated may use Hoyer lift for transfers.</p> <p>A Progress Note for Resident #10, dated 1/7/16 at 8:08 p.m., indicated she was being Hoyer lifted during a transfer and the Hoyer lift pad gave out. The note also indicated the resident slipped to the floor bumping the back of her head on the floor. The note further indicated there was copious amounts of bleeding noted, with a 3.5 cm (centimeter) x (times) 5 cm cut with a 6 cm bump. A new order was received to send the resident to the hospital.</p> <p>A hospital Emergency Room report for Resident #10, dated 1/7/16, indicated the resident was dropped from the Hoyer lift at the nursing home. The report also indicated the staff denied any loss of consciousness. A CT (Computerized Tomography) scan of her head indicated a significant scalp contusion along the high midline parietal scalp. The report further indicated the laceration to the back of her head was repaired with</p>		<p>incidents to ensure that any that meet reportable criteria were reported. If any were found not to be reported, they were reported. Further, any incidents categorized as customer service concerns were reviewed to see if they met reportable criteria as an alleged abuse. If any were found not to be reported, they were reported. Going forward, at the morning CQI meetings, any incident that appears on the 24 hour report or any incident that requires further investigation that has occurred since the previous CQI meeting will be reviewed to see if it meets reportable criteria for the ISDH. If it does, timely reporting and follow up will be validated and any further needed action will be taken. This monitoring of follow up on these events will be the responsibility of the Administrator and will be ongoing. A Regional team member reviewed the reportable criteria as set forth by the ISDH with the</p>	

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	<p>staples.</p> <p>A Progress Note for Resident #10, dated 1/7/16 at 11:50 p.m., indicated she returned from the hospital. The note also indicated there was a small amount of serosanguineous (yellow with small amounts of blood) drainage noted, swelling around the perimeter of the laceration repair, and 7 staples intact at 5 cm long.</p> <p>A Certified Nursing Assistant (CNA) Assignment Sheet for Resident #10, provided by the Director of Nursing on 2/9/16 at 9:51 a.m., indicated she was dependent on 2 staff with the Hoyer lift for transfers.</p> <p>The Administrator and Director of Nursing were interviewed on 2/9/16 at 10:05 a.m. During the interview they indicated only 1 staff transferred Resident #10 when she fell from the Hoyer lift. They also indicated the fall was not reported to the Indiana State Department of Health (ISDH) by the previous Administrator.</p> <p>B. On 2/10/16 at 11:42 p.m., LPN (Licensed Practical Nurse)#30 was interviewed. She indicated there had been an incident recently where a staff member was overheard speaking to a resident in a</p>		<p>Administrator andDON. Also, the difference between acustomer service issue and an alleged abuse issue was discussed and defined.</p> <p>An all staff inservice is being held March 2nd at which time the following is being reviewed:</p> <p>A. AbusePolicy—Reporta ble Criteria B. Resident Rights C. What to do if youbecome aware of an alleged abuse D. CustomerService—defi ned E. Questions/Answers</p> <p>Any staff who fail tocomply with the points of the in-service will be further educated and/orprogressively disciplined as indicated.</p> <p>At the monthly QA meetings the incidents that were reported as well as the customer service issues will bereviewed to see that all appropriate actions and follow up took place. Any</p>	

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	<p>manner that could have been perceived as offensive to the resident. She indicated "no matter what the situation, you have to act on them" (allegations or actual situations of abuse). She indicated the resident involved in this incident was Resident #51.</p> <p>On 2/11/16 at 10:00 am., the Administrator provided a copy of the investigation of the allegation of abuse which involved Resident #51. The investigation included, but was not limited to, the following: "On 1/26/16, I received a phone call from LPN #30 on night shift stating CNA #31 was allegedly heard telling Resident #51 to be quiet when she had asked to be helped...I came in and spoke with Resident #51. Resident #51 did not remember anything. I spoke with CNA #31 at home and got a written statement from her. She stated on the phone and in person, Monday morning 1/28/16, that she went into Resident #51's room to help her and told her to (sic) she will help her get changed and to try to be quiet because it was the middle of the night. She stated she was not condescending in any way...We discussed customer service expectations on Monday 1/28. No allegations of abuse were presented..." This investigation was signed by the Administrator.</p>		<p>concerns will be addressed. If any patterns emerge, an Action Plan will be written by the committee to address them. Any Action Plan will be monitored weekly by the Administrator until resolved.</p>	

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	<p>The investigation also included a written statement from CNA #31. The written statement included, but was not limited to, the following: "...doing my bed check and Resident #51 was saying she was wet and I told her to hold on..."</p> <p>The investigation also included a written statement from LPN #30. The written statement included but was not limited to, the following: "Staff reported what he heard from another staff. I asked if he can write a statement about the incident, which he did..."</p> <p>Documentation was lacking in the investigation of the written statement of the staff member who reported the allegation of verbal abuse to LPN #30 on 1/26/16.</p> <p>On 2/11/16 at 10:49 a.m., the Administrator indicated she did not report the incident which involved Resident #51 to the state agency. She indicated she did not report this because when she talked to LPN #30 on 1/26/16, LPN #30 relayed to the Administrator, it was more of a customer service concern with CNA #31. The Administrator indicated she did not interview any residents other than Resident #51 on 1/26/16 or the next day. The Administrator indicated CNA #31</p>			

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	<p>returned to work on 1/28/16.</p> <p>On 2/11/16 at 10:56 a.m., the Administrator was interviewed. She indicated as part of their investigation, other residents, employees and/or any witnesses would be interviewed. She indicated allegations should be reported to the state agency, "You report everything."</p> <p>On 2/11/16 at 11:22 a.m., the Administrator provided an undated copy of "Abuse Prevention Program." This copy included, but was not limited to, the following: "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect...Upon learning of the report the Administrator...shall initiate an incident investigation...For any incident involving suspicion of abuse...the Administrator...will gather further facts prior to making a determination to conduct an abuse investigation...When an alleged or suspected case of abuse...is reported to the Administrator...will notify the following persons or agencies of such incident immediately...State Licensing and Certification Agency..."</p> <p>On 2/11/16 at 11:40 a.m., the Administrator was interviewed She</p>				

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	<p>indicated she should have reported the incident which involved Resident #51 to the state agency. She also indicated she should have interviewed additional residents to see if there were other concerns of verbal abuse.</p> <p>On 2/11/16 at 12:55 p.m., the Administrator was interviewed. She indicated the "he" referred to in the LPN #30's statement was Laundry Staff #32. The Administrator indicated Laundry Staff #32 indicated as he passed by the Resident #51's room, he heard CNA #31 tell Resident #51 to be quiet. The Administrator indicated she did interview the laundry staff and requested a written statement from him but never got one.</p> <p>A current facility policy "Reportable Process to ISDH", dated 12/5/14 and provided by the Administrator on 2/9/16 at 11:16 a.m., indicated "...Reporting of incidents to ISDH are the responsibility of the administrator of the facility...Administrator or designee will report initial incident per ISDH Reportable Guidelines...It is the responsibility of the administrator to ensure all interventions in the reportable are completed and documented timely and accurately...The administrator is responsible for ensuring that the incident is thoroughly investigated..."</p>			

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F 0246 SS=D Bldg. 00	<p>3.1-28(a)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to ensure call lights were kept within reach for 3 of 35 residents observed for call lights. (Residents #37, #17 and #74)</p> <p>Findings include:</p> <p>1. An observation of Resident #37 on 2-3-2016 at 2:50 p.m., indicated the resident was sitting in the chair which was positioned in the corner of her room with a table between the chair and the</p>	F 0246	<p>It is the policy of this facility to ensure that residents live in an environment that provides accommodations to meet their individual needs and preferences while maintaining their health and safety. Call lights are kept within reach of Resident #37 as well as Resident #17 and Resident #74.</p> <p>Note: Even if the resident is</p>	03/12/2016	

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	<p>bed. The call light was observed on her bed. Resident #37 indicated she knew where the call light was when asked, and indicated she would not be able to reach the call light.</p> <p>A review of Resident #37's record began on began on 2-11-2016 at 9:03 a.m. The quarterly MDS (Minimum Data Set) assessment dated 1-7-2016 indicated the BIMS (Brief Interview for Mental Status) indicated a score of 3/15 which was severely cognitively impaired. Further review of the MDS for 1-7-2016, indicated the Resident required an extensive assist of one person for transfers, bed mobility and toileting. A review of the risk of fall care plan initiated on 6-8-2015 and provided by the Administrator on 2-11-2016 at 9:05 a.m., indicated the risk for falls was due to "...Parkinson's and arthritis, need for help with transfers...."</p> <p>The interventions initiated on 6-8-2015 indicated "...place call light within reach in room...."</p> <p>2. An observation of Resident #17 on 2-4-2016 at 1:20 p.m., indicated the resident was in her room, in her wheelchair which was parked next to the bed. The call light was observed lying across the bed with the call button between the wall and the bed.</p>		<p>not able to independently use their call light, it needs to be within their reach so staff assisting the resident could turn the call light on if they needed additional help while caring for the resident.</p> <p>All residents have the potential to be affected by this finding.</p> <p>Going forward, the DON/Designee will make rounds 5 days weekly on various shifts to ensure that call lights are within reach of the residents. Any found not to be within reach will be placed within reach of the resident. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will occur 2 days weekly on various shifts for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will take place.</p>	

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	<p>An observation of Resident #17 on 2-10-2016 at 2:35 p.m., indicated the resident was in her room in her wheelchair with the call light on the floor by the bed.</p> <p>A review of Resident's #17's record began on 2-9-2016 at 1:57 p.m. The quarterly MDS assessment dated 11-19-2015 indicated a BIMS of 3/15. Further review of the MDS indicated the resident required an extensive assist of two persons for transfers, bed mobility and toileting. A review of the risk of fall care plan revised on 9-4-2015 and provided by the Administrator on 2-11-2016 at 9:05 a.m., indicated the risk for falls was due to "...dementia, arthritis, decreased mobility and medications..." The interventions revised on 11-23-2015 indicated "...keep call light within reach in room...assist of 2 staff for all transfers...."</p> <p>3. An observation of Resident #74 on 2-8-2016 at 1:40 p.m., indicated the resident was in her room, in bed with the call light near her feet at the end of the bed. The call light was not observed to be within the resident's reach.</p> <p>A review of Resident #74's record began on 2-8-2016 at 9:38 a.m. The quarterly</p>		<p>At an in-service being held for all staff on March 2nd, the policy on Call Lights will be reviewed. The roles of various staff members will be discussed as to what they should do if they see a call light out of reach depending on their department and job description.</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly QA meeting the results of the call light placement monitoring will be reviewed. Any concerns will have been addressed as found however any patterns identified will have an Action Plan written by the committee to address. Any Action Plan will be monitored weekly by the Administrator until resolution.</p>	

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	<p>MDS assessment dated 11-27-2015 indicated a BIMS of 4/15 (severe cognitive impairment). Further review of the MDS indicated the resident required an extensive assist of 2 persons for bed mobility, transfers and toileting. A review of the fall risk care plan initiated on 11-17-2015 indicated the risk of falls was due to "...CVA (stroke), dementia, need for assistance with transfers...." The intervention revised on 5-29-2014 indicated "...place call light within reach in room and remind...to call for assistance with transfers...."</p> <p>During a interview with CNA #21 on 2-11-2016 at 3:35 p.m., the CNA indicated when leaving a resident in their room, the call light should be within reach of the resident by attaching it to the bed or the resident's chair arm.</p> <p>A current policy "Call Lights-Resident" dated 7-1-11 and provided by the ADON (Assistant Director of Nursing) on 2-11-2016 at 9:05 a.m., indicated "...ensure all call lights are placed within the residents reach at all times...."</p> <p>3.1-3(v)(1)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to follow physician orders for no shoe to left foot for 1 resident (Resident #21) with a wound to her left great toe.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #21 on 2/8/16 at 1:38 p.m., indicated the following: diagnoses included, but were not limited to, heart failure, dementia with behavioral disturbance, atrial fibrillation, edema, and major depressive disorder.</p> <p>A Wound Assessment Form for Resident #21, dated 1/20/2016, indicated an open wound on her great left toe, measuring 1.7 cm (centimeter) x (times) 2.3 cm. The assessment also indicated the wound edges were attached to the base, the periwound tissues were intact, and the wound bed had eschar (dry dark scab). The assessment further indicated the etiology was unsure, but the vascular status would be checked.</p>	F 0282	<p>It is the policy of the facility to see that physician orders are followed as written as related to resident care. Resident #21 is not wearing a shoe on her left foot. All of Resident #21's orders are being followed as written.</p> <p>Any resident who resides in the facility has the potential to be affected by this finding.</p> <p>An audit was conducted on all charts to see that all current orders were being implemented and that all CNA assignment sheets were accurate in reflecting duties to be performed by CNAs based on physician orders that would pertain to care administered by CNAs. Any concerns were corrected.</p> <p>Going forward the DON/Designee will review</p>	03/12/2016	

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	<p>A Ultrasound Report for Resident #21, dated 1/22/16, indicated a non-pressure chronic ulcer.</p> <p>A physician's order for Resident #21, dated 1/26/16, indicated no shoe worn to left foot due to left great toe ulcer.</p> <p>During an observation on 2/8/16 at 10:38 a.m., Resident #21 was observed seated in her wheelchair in her room visiting with family. She was observed wearing a shoe on her left foot.</p> <p>During an observation on 2/8/16 at 1:50 p.m., Resident #21 was observed seated in her wheelchair in her room. She was observed wearing a shoe on her left foot.</p> <p>During an observation on 2/9/16 at 8:45 a.m., Resident #21 was observed seated in her wheelchair in her room. She was observed wearing a shoe on her left foot.</p> <p>During an observation on 2/9/16 at 12:22 p.m., Resident #21 was observed seated in her wheelchair in the main dining room waiting on her lunch meal to be served. She was observed wearing a shoe on her left foot.</p> <p>During an observation on 2/10/16 at 8:39 a.m., Resident #21 was observed seated</p>		<p>10 charts weekly to see that the orders are being carried out as ordered including checking to see that the CNA assignmentsheets are accurate as per the orders that reflect CNA care. Additionally, at the daily CQI meetingsorders reviewed will be checked to see that the components of the orders are added to the care plan and the CNA assignment sheets as indicated. The monitoring of the 10 charts weekly by the DON/Designee will continue until 4 consecutive weeks of zero negative findings are achieved. After that, 2 charts will be reviewed weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing.</p> <p>An inservice for nursing staff will be held on March 2nd, the following will be reviewed:</p> <p>A. Physician Orders B. Assessments</p>	

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F 0323 SS=G Bldg. 00	<p>in her wheelchair in the lounge area of the Southwest Hall. She was observed wearing a shoe on her left foot.</p> <p>Review of the Certified Nursing Assistant Assignment Sheet on 2/9/16 at 8:51 a.m., did not indicate Resident #21 was not to wear a shoe on her left foot.</p> <p>Certified Nursing Assistant #1 was interviewed on 2/9/15 at 10:30 a.m. During the interview she indicated staff were able to determine what care each resident required on the CNA assignment sheets.</p> <p>The Administrator was interviewed on 2/10/16 at 10:00 a.m. During the interview she indicated physician orders were to be followed.</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</p>		<p>C. Care Plans D. CNA assignmentsheets/timely updates E. Question &Answers</p> <p>Any staff who fail to comply withthe points of the in-service will be further educated and/or progressivelydisciplined as indicated.</p> <p>At the monthly QA meetings theresults of the monitoring of the charts by the DON/Designee to see that ordersare being carried out and followed will be discussed. Any concerns will have been corrected asfound. Any patterns will beidentified. If needed an Action Planwill be written by the committee to address any patterns. Any Action Plan will be monitored weekly bythe Administrator until resolved.</p>		

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	<p>hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1. Based on interview and record review the facility failed to ensure 1 resident (Resident #10) of 2 residents reviewed for falls was transferred safely in a Hoyer lift. This deficient practice resulted in a fall from the Hoyer lift with a laceration to the back of her head requiring staples in the Emergency Room.</p> <p>2. Based on observation, interview and record review the facility failed to ensure hot water was within the acceptable range on the Southwest Hall in 8 of 8 resident bathrooms, potentially affecting 15 of 15 residents.</p> <p>3. Based on observation, interview and record review the facility failed to ensure personal care products were stored safely, a medication cart drawer and a beauty shop door and a soiled utility room door were secured from mobile and confused residents. This deficient practice had the potential to affect 13 confused and mobile residents of the 83 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #10 on 2/8/16 at 8:30 a.m., indicated the following: diagnoses</p>	F 0323	<p>It is the policy of the facility to see that the environment of the residents remains as free of accident hazards as possible. Further, the facility provides adequate supervision and assistive devices to prevent accidents. Resident #10 is transferred safely and per order and care plan with proper and safe technique. Water temps on the Southwest Hall is within acceptable temp ranges in the resident bathrooms. This includes the following room numbers, 12, 201, 202, 203, 204, 205, 206, 207, 208, 209, and 210. Only the Maintenance staff can adjust water temps. Personal care products are stored safely. Products labeled: Keep Out Of The Reach Of Children are safely secured. Med Carts are locked at all times except when being used and under the direct supervision of a nurse. No product that is labeled Keep Out Of The Reach Of Children is left in an accessible place on the med cart. The Beauty Shop is locked unless the licensed beautician is in it and supervising the products and equipment. The Soiled Utility Room doors are secured/locked unless appropriate staff are in the room working and supervising to see that no residents enter. The counter</p>	03/12/2016

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	<p>included, but were not limited to, Alzheimer's disease, muscle weakness, dementia, contracture, abnormal posture, and unspecified dementia with behavioral disturbance.</p> <p>A physician's order for Resident #10, dated 10/12/15, indicated may use Hoyer lift for transfers.</p> <p>A Minimum Data Set assessment for Resident #10, dated 11/23/15, indicated she was totally dependent on staff with the physical assistance of 2 staff for transfers.</p> <p>A Fall Risk Assessment for Resident #10, dated 11/23/15, indicated she was at risk for falls due to: disoriented x (times) 3 at all times, chair bound, poor vision, took 1-2 of the medications (anesthetics (pain), antihistamines (allergy), antihypertensives (blood pressure), antiseizure, benzodiazepines (tranquilizer), carthartics (purgative), diuretics, hypoglycemics, narcotics (mood or behavior), psychotropics, sedative/hypnotics) currently and/or within 7 days, and had 1-2 predisposing diseases (hypotension (low blood pressure), vertigo (lightheaded), CVA (stroke), Parkinson's disease, loss of limb(s), seizures, arthritis, osteoporosis (brittle bones), fractures). The</p>		<p>at the Nurses' Station do not have products sitting on them that are labeled Keep Out Of The Reach Of Children unattended. All residents have the potential to be affected by this finding. The DON/Designee will monitor 3 Mechanical Lift transfers 3 days a week to ensure that the transfers are done safely using proper technique. Any concerns will be corrected as discovered to prevent any negative outcome. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, this monitoring will occur for 3 Mechanical Lift transfers 1 day weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Water temps will be taken in random resident bathrooms by the Maintenance staff at a rate of 6 bathrooms (and the shower room) per hallway 5 days weekly at random times of day. This temp taking will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 6 bathrooms (and the shower room) per hallway will be checked for water temps 1 day weekly for a period of not less than 6 months to ensure ongoing compliance. After that, temps will be taken in resident bathrooms and shower rooms as per the Preventive Maintenance Program. Any concerns with the</p>	

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	<p>assessment also indicated she was lifted with a Hoyer lift and 2 staff into a reclining wheelchair and into bed.</p> <p>A Progress Note for Resident #10, dated 1/7/16 at 8:08 p.m., indicated she was being Hoyer lifted during a transfer and the Hoyer lift pad gave out. The note also indicated the resident slipped to the floor bumping the back of her head on the floor. The note further indicated there was copious amounts of bleeding noted, with a 3.5 cm (centimeter) x 5 cm cut with a 6 cm bump. A new order was received to send the resident to the hospital emergency room.</p> <p>A hospital Emergency Room report for Resident #10, dated 1/7/16, indicated the resident was dropped from the Hoyer lift at the nursing home. The report also indicated the staff denied any loss of consciousness. A CT scan of her head indicated a significant scalp contusion along the high midline parietal scalp. The report further indicated the laceration to the back of her head was repaired with staples.</p> <p>A Progress Note for Resident #10, dated 1/7/16 at 11:50 p.m., indicated she returned from the hospital. The note also indicated there was a small amount of serosanguineous (yellow with small</p>		<p>water temps will be addressed as found. No water will be used that falls outside of the temperature parameters as per the state guidelines. The DON/Designee will monitor resident rooms/shower rooms/med carts/nurses' station countertops 3 days weekly to see that there are no unsecured products that are labeled Keep Out Of The Reach Of Children. Any products found will be immediately removed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring will occur 1 day weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. The DON/Designee will monitor to see that med carts are locked when not under the direct supervision of a nursing staff member who passes meds. Also, that the Beauty Shop is locked when unattended. Further, that the Soiled Utility Rooms are locked if no appropriate staff are in the room working. This monitoring will occur 3 times daily on 3 days weekly. Any concerns will be corrected as found. The monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will occur 1 x daily 3 days weekly for a period of not less than 6 months to ensure</p>	

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	<p>amount of blood) drainage noted, swelling around the perimeter of the laceration repair, and 7 staples intact at 5 cm long.</p> <p>Review of the fall investigation for Resident #10, dated 1/7/16, indicated Certified Nursing Assistant (CNA) #2 thought she could transfer her in the Hoyer lift by herself.</p> <p>A CNA Assignment Sheet for Resident #10, provided by the Director of Nursing on 2/9/16 at 9:51 a.m., indicated she was dependent on 2 staff with the Hoyer lift for transfers.</p> <p>A facility care plan for Resident #10, with a review date of 11/23/15, indicated the focus area of resident was at risk for falls due to the diagnosis of dementia, use of antidepressant medication, and she was dependent on staff for transfers. Interventions to the focus included, but were not limited to, keep resident in a visible area when she is in her wheelchair, and keep call light placed within reach in room.</p> <p>The Administrator and Director of Nursing were interviewed on 2/9/16 at 10:05 a.m. During the interview they indicated only 1 staff transferred Resident #10 when she fell from the Hoyer lift.</p>		<p>ongoing compliance. After that, random monitoring will occur. At an all staff in-service being held on March 2nd, the following will be reviewed:</p> <p>A. Safety/Accident Prevention/Keep Out Of The Reach Of Children—label B. Following safe practices with emphasis on Mechanical Lift transfers</p> <p>C. Water Temps—Range/When to report/How to report and to whom/Who can adjust?</p> <p>D. Locked Areas (Med Carts/Med Rooms/Beauty Shop/Soiled Utility Rooms/Other</p> <p>E. Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring of water temps by the maintenance staff and the hazardous products and secured/locked areas by the DON/Designee will be reviewed. Any patterns will be identified and an Action Plan will be written by the committee to address the pattern(s) as necessary. Any Action Plan will be monitored by the Administrator weekly until resolved.</p>		

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	<p>The also indicated the fall was not reported to the Indiana State Department of Health by the previous Administrator.</p> <p>CNA #1 was interviewed on 2/9/15 at 10:30 a.m. During the interview she indicated staff were able to determine what care each resident required on the CNA assignment sheets.</p> <p>CNA #3 was interviewed on 2/10/16 at 5:00 p.m. During the interview she indicated 2 staff were to be used when transferring a resident on a Hoyer lift.</p> <p>The Administrator was interviewed on 2/11/16 at 9:50 a.m. During the interview she indicated it was the policy of the facility for 2 staff to operate a Hoyer lift.</p> <p>A current facility policy " Manual Lift", issued on 7/1/11 and provided by the Corporate Vice President on 2/11/16 at 10:05 a.m., indicated "...It is the intent of the facility that Hoyer lifts are used to enable staff to lift and move a resident safely...."</p> <p>2. During a resident interview on 2/3/16 at 11:15 a.m., Resident #12 indicated the hot water in her bathroom sink was very hot. She also indicated she had told Maintenance #4 about the hot water, but</p>			

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	<p>he must have forgotten to check it. When the running hot water was checked in the bathroom of Room 204 with a thermometer by the surveyor, the hot water registered at 136 degrees.</p> <p>The hot water temperatures in the bathrooms in following rooms on the Southwest Hall were checked with the following results:</p> <p>At 11:18 a.m., the hot water temperature in the bathroom of Room 205 registered at 134 degrees.</p> <p>At 11:21 a.m., the hot water temperature in the bathroom of Room 206 registered at 132.3 degrees.</p> <p>At 11:23 a.m., the hot water temperature in the bathroom of Room 208 registered at 132.8 degrees.</p> <p>At 11:25 a.m., the hot water temperature in the bathroom of Room 209 registered at 134.1 degrees.</p> <p>At 11:27 a.m., the hot water temperature in the bathroom of Room 210 registered at 134 degrees.</p> <p>At 11:30 a.m., the hot water temperature in the bathroom of Room 203 registered at 137.3 degrees.</p>			

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	<p>At 11:33 a.m., the hot water temperature in the bathroom of Room 202 registered at 132.6 degrees.</p> <p>The temperature of the hot water in the bathroom of Room 207 was not able to be checked due to the resident was using the bathroom.</p> <p>The Resident #12 was interviewed again on 2/8/16 at 10:38 a.m. During the interview she indicated she notified Maintenance #4 about the hot water on Monday, February 1, 2015, after she received her bath.</p> <p>A review of the Shower Sheet for the Southwest Unit on 1/9/16 at 8:50 a.m., indicated she had received a bath during the day on 2/1/15.</p> <p>Water Temp Logs, provided by the Administrator on 2/11/16 at 9:57 a.m., for the Southwest Hall indicated the following:</p> <p>On 1/29/16, the hot water temperatures were: 108 degrees in Room 203, 111 degrees in Room 205, 110 degrees in Room 206, 110 degrees in Room 110, and 111 degrees in Room 209.</p> <p>On 2/5/16, the hot water temperatures</p>			

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	<p>were: 108 degrees in Room 201, 103 degrees in Room 202, 103 degrees in Room 204, 101 degrees in Room 207, and 102 degrees in Room 210.</p> <p>The Administrator was interviewed on 2/11/16 at 9:30 a.m. During the interview she indicated a staff member working on the 3rd shift had been turning up the hot water heater to its highest level so the water would be hot in the morning for the resident's baths and showers.</p> <p>Maintenance #5 was interviewed on 2/1/16 at 10:30 a.m. During the interview he indicated he had checked the water temperatures on 2/3/16 after the surveyor checked the water temperatures and they were too hot. He indicated he immediately turned the temperature on the hot water tank down. He also indicated the hot water tank for the Southwest Hall was located in the locked soiled utility room. He further indicated a spot was marked on the dial of the hot water tank indicating where the temperature level was to be kept. He also indicated a staff member on 2nd or 3rd shift had turned the dial of the hot water tank to a higher temperature because they felt the hot water was not "hot enough." He further indicated only maintenance staff were to adjust the temperature of the hot water tank. He indicated</p>			

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	<p>maintenance checked the water temperatures weekly or more often as needed.</p> <p>The Administrator was interviewed on 2/11/16 at 12:56 p.m. During the interview she indicated hot water should not be above 120 degrees.</p> <p>A current facility policy "Water Temperature", dated 2/17/15 and provided by the Administrator on 2/11/16 at 12:55 p.m., indicated "Maintenance will be auditing proper water temperature throughout the building weekly as part of the Preventative Maintenance program...Staff is to report any concerns, whether from family or resident, about the temperature of water to Maintenance immediately and fill out a requisition...."</p> <p>3. An observation in the skilled unit on 2-3-2016 at 9:45 a.m., indicated an unattended medication cart was observed next to an unattended nurse station with the second drawer of full medication cards and medication bottles unsecured. There were 18 residents sitting toward the end of the nurse station with one activity person with her back toward the medication cart conducting a memory activity. One resident was observed at the other side of the nurse station propelling himself in his wheelchair.</p>			

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	<p>An interview with LPN #20 on 2-3-2016 at 9:46 a.m., indicated as she returned to the medication cart she commented "the card must have been stuck" in regard to the unsecured medication cart drawer.</p> <p>An observation of an unlocked cabinet outside the North unit shower room on 2-3-2016 at 10:50 a.m., indicated a 4 ounce spray can of deodorant and body spray was on a lower shelf. The label indicated "...keep out of reach of children...if swallowed get medical help or contact the Poison Control Center right away...."</p> <p>An observation of the unlocked and unattended South unit shower room on 2-4-2016 at 9:30 a.m., indicated there was a 4 ounce tube of medicated barrier cream on top of a dirty laundry hamper just under a locked cabinet. At 9:31 a.m., CNA #28 entered the shower room. An interview at that time with CNA #28 indicated the cream should be locked in the cabinet.</p> <p>An observation of the beauty shop on 2-4-2016 at 9:50 a.m., indicated the beauty shop room door was open, the shop was unattended by staff and a resident was sitting in her motorized cart with color on her hair. The beauty shop had products out on the counter as</p>			

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	<p>follows, an opened container of a brown, thick substance (remainder of the color), several cans of hair spray, hair shaping spray, "brand" temporary hair color, oil for clippers, mousse, antidandruff shampoo, and barbicide in a glass container. Hair stylist #29 returned about 9:51 a.m. She indicated she was checking on something for the resident in her room. An interview with Hair Stylist #29 indicated when she leaves for the day all the beauty products are locked up. Further interview with Hair Stylist #29 indicated she was not aware that she should not leave the beauty shop unattended with the door opened even with a resident who was aware.</p> <p>An observation in the skilled unit on 2-8-2016 at 9:50 a.m., indicated the soiled utility room door being ajar. The door handle had a push button lock on it. An observation inside the soiled utility room included a container of sani cloths and a 32 ounce spray bottle of disinfectant inside an unlocked cabinet.</p> <p>An observation on the skilled unit on 2-8-2016 at 1:26 p.m., indicated the soiled utility room door was ajar with no staff inside the room and the unlocked cabinet inside the room contained the disinfectant and sani wipes.</p>			

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	<p>An observation of the Skilled unit nurse station on 2-8-2016 at 3:30 p.m., indicated a 4 ounce bottle of hand sanitizer with "...keep out of reach of children..." on the label, was out on the nurse station lower shelf within reach of residents and there were at least 3 residents in the area.</p> <p>An observation in the South unit on 2-9-2016 at 4:13 p.m., indicated a 4 ounce bottle of hand sanitizer was out on the medication cart after LPN #30 used it and left the cart unattended.</p> <p>An observation in the Skilled unit on 2-9-2016 at 4:20 p.m., indicated a 4 ounce bottle of hand sanitizer was out on the unattended nurse station counter with Resident #104 walking around the station.</p> <p>An observation in the Skilled unit on 2-9-2016 at 5:05 p.m., indicated two 4 ounce bottles of hand sanitizer were out on the counter and unattended in the skilled nurse station counter along with one 8 ounce spray bottle of peri cleanser that was on an open shelf inside the nurse station with "...keep out of reach of children..." on the label.</p> <p>An observation of the South unit medication cart on 2-10-2016 at 8:15</p>			

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	<p>a.m., indicated a 4 ounce bottle of hand sanitizer was in the side compartment of the cart while the cart was left unattended in the hall. At 8:30 a.m., the unattended medication cart was outside room 13 with the hand sanitizer in the side compartment and a resident was independently propelling herself in the hall in her wheelchair toward the cart.</p> <p>An interview with the DON on 2-11-2016 at 12:10 p.m., indicated she was not aware that a nurse left a medication cart drawer in the skilled unit open and unattended.</p> <p>A MSDS (Material Safety Data Sheet) for "brand" germicidal disposable wipes dated 3-11-2011 and provided by the Administrator on 2-10-2016 at 4:30 p.m., indicated "...for eye contact...immediately flush with plenty of water...call a poison control center or doctor for treatment advice...keep out of reach of children..."</p> <p>A MSDS for pH7Q Ultra disinfectant dated 9-25-2012 and provided by the Corporate Vice President on 2-11-2016 at 1:12 p.m., indicated "...corrosive...harmful if swallowed...causes eye and skin irritation...toxic if swallowed...risk of serious damage to eyes...put on appropriate personal protective</p>			

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	<p>equipment...wash hands and face before eating, drinking...do not get in eyes or on skin or clothing...do not breathe vapor or mist...do not ingest...."</p> <p>A Safety Data Sheet for Barrier Cream dated 1-12-2012 and provided by the ADON (Assistant Director of Nursing) on 2-11-2016 at 1:18 p.m., indicated "...for ingestion...do not induce vomiting unless direct to do so...get medical attention if symptoms appear...."</p> <p>A Safety Data Sheet for "brand" hand sanitizer dated 8-18-2014 and provided by the Corporate Vice President on 2-11-2016 at 1:12 p.m., indicated "...emergency first aide procedures...ingestion-nausea, vomiting and diarrhea, drink water...."</p> <p>A Safety Data Sheet for Perifresh dated 8-18-2014 and provided by the Corporate Vice President on 2-11-2016 at 1:12 p.m., indicated "...emergency first aide procedures...flush eyes with water for 15 minutes...if ingested drink large amount of water...call physician...."</p> <p>Copies of a hair spray label and shaping hair spray label were provided by the Administrator on 2-11-2016 at 12:59 p.m. and indicated "...keep out of reach of children...."</p>			

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	<p>A copy of the clipper oil label provided by the Administrator on 2-11-2016 at 12:59 p.m., indicated "...danger...harmful or fatal if swallowed...call physician immediately...keep out of reach of children...."</p> <p>A review of the actual containers provided by the Hair Stylist #29 on 2-11-2016 at 2:00 p.m., indicated the following for the barbicide label "danger...keep out of reach of children....", for the temporary hair color bottle "...keep out of reach of children...." was on the label and for the anti dandruff shampoo bottle "...keep out of reach of children...if swallowed get medical help or contact poison control center right away...." was on the label.</p> <p>A current policy "Medication Storage in the Facility" dated 7-21-2014 and provided by the DON on 2-11-2016 at 11:00 a.m., indicated "....medication rooms, carts, and medication supplies are locked or attended by person with authorized access...licensed nurses...."</p> <p>A current policy "Safe Chemical Storage" was undated and provided by the DON on 2-10-2016 at 4:25 p.m., indicated "...it is the policy...to ensure that the resident environment remains as free of accidents</p>			

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F 0332 SS=D Bldg. 00	<p>and hazards as is possible...all cabinets used to store chemicals...will be secured with locks...chemicals will be in locked storages at the nurse's stations and in shower rooms...."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure the medication administration error rate did not exceed 5%, as 20 of 38 medication administration opportunities observed were errors for 3 residents, which resulted in an error rate of 52.6%. (Resident #45, #15 and #58)</p> <p>Findings include:</p> <p>An observation of the medication pass for Resident #45 on 2-9-2016 at 8:08 a.m., indicated LPN #23 prepared the medications for a g-tube (gastrostomy tube) by placing 6 medications in a</p>	F 0332	<p>It is the policy of the facility to see that meds that are administered at an error rate of less than 5% as per regulation requirement. Resident #45, Resident #15 and Resident #58 all receive their meds accurately and per physician order.</p> <p>Any resident who receives medications via a feeding tube or who is to receive meds with meals/food in the facility has the potential to be affected</p>	03/12/2016

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	<p>medication cup as follows, an allopurinol (for gout) 100 mg (milligram) tab, a baclofen (for muscle spasms) 10 mg tab, a metformin HCl (Hydrochloride) (for diabetes) 500 mg tab, 2 acetaminophen (for pain) 325 mg tablets and a lisinopril (for high blood pressure) 2.5 mg tab. The 6 pills were observed to be crushed together in a plastic pouch and the crushed pill contents were poured into a medication cup. A Nuedexta (for pseudobulbar affect) 20-10 mg capsule was observed to be opened by LPN #24 and the contents sprinkled on the crushed medications. The nurse was observed to wash her hands, don gloves, check placement of the g-tube after stopping the enteral feeding and then filled the syringe with tap water. The water was observed not to flow by gravity. LPN #24 was observed to place the plunger in the syringe and push gently and the water was instilled. LPN #24 was observed to remove the plunger and then dump the dry medications in the syringe. She then was observed to add some water to the syringe and the crushed medications did not move from the syringe. She then obtained the plunger and placed it in the syringe and pushed, but the medications did not instill into the g-tube. LPN #24 was observed to remove the syringe and she pushed the remaining medications</p>		<p>by this finding.</p> <p>The DON/Designee will monitor 3feeding tube med passes 3 days weekly on various shifts to see that thefacility's policy and procedure is followed. Further, the DON/Designee will monitor 3 residents 3 days weekly who areto receive meds with meals or food to see that the med is administered perorder and policy. Any concerns observedwill be halted and corrected prior to an error being committed. This monitoring will continue until 4consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring will occur for 3residents who receive meds via feeding tube and 3 residents who receive medswith meals/food 1 day weekly for a period of 6 months to ensure ongoingcompliance. After that, random auditswill occur.</p> <p>An in-service being heldon</p>	

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	<p>into a cup of water. She then poured the cup of water with the medications into the syringe, placed the plunger in the syringe and pushed the rest of the medication solution into the g-tube. She then removed the syringe and then the plunger and re-attached the syringe to the g-tube and added the rest of the water into the g-tube. The syringe was removed and the enteral feeding was re-connected.</p> <p>A review of the current physician orders provided by the ADON (Assistant Director of Nursing) on 2-9-2016 at 11:33 a.m., indicated the following:</p> <p>May administer medications together per g-tube with an order date of 2-5-2016.</p> <p>An interview with the DON (Director of Nursing) on 2-9-2016 at 8:29 a.m., indicated the g-tube medications can be crushed and administered together with a pharmacy order. The DON indicated the crushed medications cannot be dumped dry into the syringe and should have been mixed with water prior to pouring in the syringe.</p> <p>An interview with LPN #24 on 2-10-2016 at 11:23 a.m., indicated she gave the g-tube medications mixed and crushed together because the pharmacist</p>		<p>March 2nd, for nursing staff who administer meds the following will be reviewed:</p> <p>A. Medication Administration—Via Feeding Tube</p> <p>B. Medication Administration—Per order including with meals/food</p> <p>C. Questions and Answers</p> <p>At the monthly QA meetings, the results of the monitoring of this medication administration will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator until resolution.</p>	

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	<p>reviewed the medications and said they could and the physician signed the order. LPN #24 indicated she should have not dumped the dry crushed medications into the syringe without first mixing the dry, crushed medication mixture with water.</p> <p>2. An observation of the medication pass for Resident #15 on 2-9-2016 at 4:30 p.m., indicated LPN #24 administered Renvela (a medication to prevent low calcium) 0.8 gram packet mixed with water to Resident #15. After LPN #24 administered the Renvela, the nurse indicated to the resident that supper would be in about 30 minutes. A review of the physician orders indicated the Renvela was to be given with meals. No snack was observed to be offered to the resident and the supper tray was observed to be delivered to the resident at 5:10 p.m.</p> <p>An interview with LPN #26 on 2-10-2016 at 4:51 p.m., indicated for a medication ordered to be given with meals, she would give the medication to the resident right before they went down to the dining room which would be 10-15 minutes prior to the meal service.</p> <p>3. An observation of the medication pass for Resident #58 on 2-10-2016 at 8:58 a.m., indicated QMA #27 (Qualified</p>			

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	Medication Aide) prepared the medications for a g-tube (gastrostomy tube) as follows, a packet of Nexium 40 mg packet was opened an dumped into a small cup with 30 ml (milliliters) of water added and set aside. QMA #27 was observed to obtain the following, an aspirin 81 mg tab, a baclofen 20 mg tab, a "brand" plus tab (vitamin) and a tizanidine (for Multiple Sclerosis) 2 mg tab and placed them into one medication cup. QMA #27 dumped the 4 pills into a small plastic bag, crushed the tablets and put the crushed contents in to a small medication cup. QMA #27 obtained a Namenda (for dementia) XR (extended release) 28 mg capsule, opened the capsule onto the crushed medications and then added the crushed contents to the container of Nexium and water. QMA #27 obtained and measured the following liquid medications, UTI stat liquid (for urinary tract infection history) 30 ml, oxybutynin Chloride syrup (for bladder spasms) 5 ml, silace liquid (for constipation) 5 ml, SMZ-TMP suspension 200-40/5 (antibiotic) 20 ml, ferrous sulfate elixir (iron) 7.4 ml, escitalopram oxalate 5 mg/ml (antidepressant) 5 ml and vitamin C syrup 5 ml and mixed them together in a small cup. QMA #27 was then observed to pour the liquid medications into the crushed medications/capsule contents			

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	<p>mixture. The liquid mixture was observed to have had pill particles that could be seen floating in the liquid. QMA #27 was observed to wash hands, don gloves, stop the tube feeding, check for placement and residual of the g-tube. Water was added to the syringe up to the end of the barrel and the water did not move until she placed the plunger on top and removed. When the water was almost instilled, QMA #27 added some of the liquid mixture of medications. The liquid medication mixture was slow to instill and the QMA had to place the plunger on top, then removed the plunger and the solution went down well. The QMA added the rest of the medication solution and flushed with the rest of the 200 ml of water. The QMA then reconnected the tube feeding.</p> <p>A review of the medication orders for Resident #58 indicated on 2-5-2016 an orders indicated "...may administer medications together per g-tube...."</p> <p>An interview with Pharmacist #25 on 2-10-2016 at 10:35 a.m., indicated the facility contacted her about administering medications together for g-tube residents. The Pharmacist indicated she must have not been clear about her statement and she indicated she meant the medications ordered for a resident with a g-tube could</p>			

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	<p>be administered together during the same pass, meaning still given separately with water and water flushed before and after each medication. The Pharmacist indicated she was not aware the nursing staff was crushing the medications together, mixing with the liquid medications and instilling all together.</p> <p>An interview with the ADON on 2-10-2016 at 11:49 a.m., indicated they asked the pharmacist about giving G-tube medications together and provided the following documentation which was dated 2-5-2016, "...it was requested that I take a look at the medications for the following residents to ensure there were no interactions when given together...upon review, I find no reason they could not be administered together..." The letter referred to Resident #45 and #58 and was signed by the Pharmacist #25. Further interview with the ADON, indicated it was assumed that meant the medication for a resident's G-tube medication pass could all be mixed together in a cup and instilled all together through the syringe into the g-tube.</p> <p>A current policy "Enteral Tube Medication Administration" dated 6-19-2016 and provided by the DON (Director of Nursing) on 2-9-2016 at 9:50</p>			

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	<p>a.m., indicated "...interactions between medications...and interactions of multiple medications are considered before administering medications through the enteral tube...if a tablet must be crushed, be sure it is crushed finely and dispersed well in warm water...used 30 to 60 ml syringe with approximately 30 ml of warm water to rinse feeding tube before and after giving medication via tube...do not mix medications together..."</p> <p>An updated policy "Enteral Tube Medication Administration Procedure" dated 2-11-2013 and provided by the Administrator on 2-11-2016 at 10:30 a.m., indicated "...prepare medications for administration...crush tablets and dissolve in water or other appropriate liquid...empty capsule contents in 5 ml to 50 ml of water or other appropriate liquid...may dilute liquid with 5 ml to 50 ml of additional liquid using up to 60 ml of liquid for highly concentrated solutions if necessary...administer each medication separately...administer medications via syringe slowly into tube...administer liquid medications first, then those that need to be diluted...reserve thick medications, e.g., antacids, for last...allow medication to flow down the tube via gravity...do not push medications through the tube...give gentle boosts with the plunger if the</p>			

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F 0353 SS=E Bldg. 00	<p>medication will not flow by gravity...flush the tube in between medications...."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review the facility failed to ensure sufficient staffing</p>	F 0353	It is the policy of the facility to see that there is sufficient nursing staff to meet the needs of the residents as per their care plans	03/12/2016

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	<p>to meet the needs of the residents per 6 of 15 confidential resident interviews, 1 confidential family interview, and confidential interviews with staff (Certified Nursing Assistants #3, #6, #7, #8, #9, #10, #11, #12, and #13) potentially affecting 83 of 83 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During resident interviews conducted on 2/3/16, 2/4/16, and 2/5/16, 6 of 15 residents interviewed indicated there were not enough staff in the facility to meet their needs. Their confidential comments included the following:</p> <p>On 2/3/16 at 11:26 a.m., an anonymous resident interview indicated the facility did not do much for her. She also indicated her fingernails were long and needed to be cut. The resident further indicated she had to wait a long time for staff to answer the call light, sometimes up to 2 hours.</p> <p>On 2/3/16 at 1:41 p.m., an anonymous resident interview indicated it took a long time for the call light to be answered, sometimes a wait of 45 minutes. The resident also indicated on a daily basis staff turn the call light off at the desk instead of coming into her room to help.</p>		<p>and any related issues of care. All residents have the potential to be affected by this finding. The DON/Administrator have met and discussed staffing patterns. The nursing schedule is reviewed daily by the Administrator and DON so that adequate staffing can be scheduled. There is Regional support in place to review any pertinent needs and help to develop a plan to address any staffing needs. There is the availability of a weekly staffing call with the corporate team as needed to ensure adequate staffing level action plan discussion. The DON/Designee will interview 10 staff members weekly on various shifts to see if they feel there is adequate staff to meet the needs of the residents. Additionally, The DON/Designee will monitor 10 interviewable residents and/or families weekly to see if they feel there is adequate staffing to meet the needs of the residents. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 staff members and 3 residents or family members will be interviewed weekly related to staffing levels. This will continue for a period of 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: Any concerns will be addressed as discovered. At an inservice being held on March 2nd for nursing staff, Resident</p>				

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	<p>The resident further indicated her call light might be on for an hour during the 3rd shift and no one came to answer it. The resident also indicated her room was off the beaten path, but staff should be able to see the light.</p> <p>On 2/4/16 at 10:00 a.m., an anonymous resident interview indicated the facility worked really short staffed at times. The resident also indicated when staff called in sick, they were not always replaced.</p> <p>On 2/4/16 at 1:14 p.m., an anonymous resident interview indicated the facility was short staffed in the evening and she had to wait for her call light to be answered.</p> <p>On 2/4/16 at 2:44 p.m., an anonymous resident interview indicated there was not enough help on the 3rd shift, particularly on the weekend. The resident also indicated she was told by staff the facility was cutting staff hours due to the census being low. The resident further indicated there had only been one nurse and one CNA on her hall on the 3rd shift.</p> <p>On 2/5/16 at 9:18 a.m., an anonymous resident interview indicated there was not enough staff in the facility.</p> <p>2. A family member of a resident residing</p>		<p>Rights, ADLs, Call Lights and Accommodation of Needs will be reviewed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring will be reviewed. Any patterns will be identified and an Action Plan will be written by the committee if needed. The Administrator will monitor any Action Plan weekly until resolved.</p>				

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	<p>in the facility was confidentially interviewed on 2/4/16 at 10:36 a.m. During the interview the family member indicated there were not enough staff working in the facility.</p> <p>3. Confidential interview with the facility staff indicated the following:</p> <p>CNA #3 was interviewed on 2/10/16 at 3:41 p.m. During the interview the CNA indicated staff called off work frequently, often leaving her with 17 residents to care for. The CNA also indicated weekends were the worst.</p> <p>CNA #6 was interviewed on 2/10/16 at 3:46 p.m. During the interview the CNA indicated there was not enough help in the facility for staff to get their work done. The CNA also indicated the facility was not always able to replace staff who had called off from work, at times leaving her to care for 14 residents.</p> <p>CNA #7 was interviewed on 2/10/16 at 3:55 p.m. During the interview the CNA indicated she usually worked on the weekends, but was working as a replacement for a staff who could not make it to work. The CNA also indicated staffing levels in the facility depended on the day.</p>			

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	<p>CNA #8 was interviewed on 2/10/16 at 3:58 p.m. During the interview the CNA indicated the facility did not have enough staff working to take care of the residents. The CNA also indicated the facility was not always able to find a replacement for staff who called off from work. The CNA further indicated at times she would be responsible for 15 - 16 residents. The CNA also indicated when working on 3rd shift, at times there was only 1 nurse and herself to take care of 32 residents.</p> <p>CNA #9 was interviewed on 2/11/16 at 8:41 a.m. During the interview the CNA indicated there were not enough staff working in the facility to meet all the needs of the residents. The CNA also indicated the facility was not always able to find a replacement for staff who called off from work, at times leaving her to care for 14 residents.</p> <p>CNA #10 was interviewed on 2/11/16 at 8:43 a.m. During the interview the CNA indicated when all staff scheduled to work were working in the facility, things were fine. The CNA also indicated when staff called off from work it made things rough for those staff who were working. The CNA further indicated she has cared for 15 residents at times.</p>			

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	<p>CNA #11 was interviewed on 2/11/16 at 8:56 a.m. During the interview the CNA indicated it depended on the day whether there were enough staff working in the facility.</p> <p>CNA #12 and CNA #13 were interviewed on 2/11/16. During the interview they indicated the facility needed more staff. They also indicated when working short staffed they were not able to provide all the care each resident required, but they did their best.</p> <p>4. The Resident Census and Conditions of Resident report, dated 2/3/16 and provided by the Director of Nursing, indicated the following:</p> <p>For bathing: 75 residents required the assistance of 1 or 2 staff, and 8 residents were dependent on staff.</p> <p>For dressing: 80 residents required the assistance of 1 or 2 staff, and 2 residents were dependent on staff.</p> <p>For transferring: 78 residents required the assistance of 1 or 2 staff, and 4 residents were dependent on staff.</p> <p>For toilet use: 78 residents required the assistance of 1 or 2 staff, and 4 residents were dependent on staff.</p>			

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	<p>For eating: 79 residents required the assistance of 1 or 2 staff, and 3 residents were dependent on staff.</p> <p>5. Information provided by the Director of Nursing on 2/11/16 at 10:50 a.m., indicated 4 residents in the facility required the use of a Hoyer lift for transfers and 4 residents in the facility required the use of a stand-up lift for transfers.</p> <p>6. Review of Resident Council Minutes on 2/11/16 at 11:25 a.m., indicated the following:</p> <p>On 6/18/15, a concern was voiced call lights were not being answered.</p> <p>On 8/10/15, a concern was voiced over the low staffing level in the facility.</p> <p>The Administrator and the Regional Vice President were interviewed on 2/11/16 at 9:40 a.m. During the interview they indicated there had been a great turnover in staff when the previous Administrator was still employed in the facility. They also indicated they were working hard to hire new staff since the new Administrator started on 1/13/16.</p> <p>3.1-17(a)</p>			

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food and beverages kept in the pantry freezers/refrigerators and cabinets were properly sealed, labeled, and dated, failed to maintain clean microwaves, and failed to ensure a small plastic glass was not stored inside a plastic container of coffee. This deficient practice had the potential to affect 81 of 83 residents who received food and beverages stored in the facility pantries.</p> <p>Findings include:</p> <p>1. During an observation of the pantry in the Northwest unit on 2-3-2016 at 10:30 a.m., the following was observed:</p> <p>The bottom of the refrigerator was not clean with splatters and a pink color on the bottom.</p>	F 0371	<p>It is the policy of the facility to see that foods/beverages kept in the pantry areas and the refrigerators within the pantry areas are properly sealed/labeled/dated and stored.</p> <p>The refrigerator and the microwave oven in the Northwest Unit pantry have been thoroughly cleaned. The opened can of thickener has been discarded. The opened cookie tin has been returned to the resident and the cookies discarded. The oatmeal/raisin cookies have been discarded. The powdered drink mix has been discarded. The cabinets and floor have all</p>	03/12/2016

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	<p>The microwave was not clean with splatters on the inside.</p> <p>The unlocked cabinets contained a can of thick and easy powder which was opened and did not have an opened date</p> <p>An opened cookie tin was labeled with a resident name and without an opened date.</p> <p>An oatmeal raisin cookie package was labeled with a resident name and had a use by sticker with a date of 12-3-2015.</p> <p>An opened 19 ounce container of powdered drink mix was not labeled with a date opened or resident name.</p> <p>The bottom cabinet shelf was not clean and had scattered, brown colored debris on it with some stains and splatters.</p> <p>The floor was not clean.</p> <p>2. During an observation of the pantry in the Skilled unit on 2-3-2016 at 10:40 a.m., the following was observed:</p> <p>The freezer contained 2 covered black containers without a name or description of contents and they were not dated.</p>		<p>been cleaned.</p> <p>In the Skilled Unit Pantry anyunlabeled or undated items have been discarded. This includes the coffee container and the scoop that was down in thecoffee. The microwave oven has beencleaned.</p> <p>In the Southwest Unit pantry thecounter top has been cleaned as well as the microwave oven. The floor has beenthoroughly cleaned. All unlabeled orundated food in facility bowls has been discarded.</p> <p>In the ICF area, the food in the undatedand unlabeled facility bowls has been discarded. All undated or unlabeled orexpired food or drink in the refrigerator has been discarded.</p> <p>In the Southwest Hall the microwavehas been cleaned and all unlabeled, undated or expired food has been discarded.</p> <p>In the Northwest Hall the tub ofdrink mix, cookies and candy have been discarded.</p> <p>On the Skilled Hall pantry themicrowave oven has</p>	

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	<p>The refrigerator contained an opened 1/2 gallon of whole milk that was not dated when opened.</p> <p>There was an unopened 16.9 ounce bottle of Mountain Dew without a name on it.</p> <p>Inside the upper left cabinet was a clear container labeled coffee with a date of 1-27-2016 and a plastic cup was inside the container in the coffee.</p> <p>The microwave was not clean and had splatters on the inside.</p> <p>3. On 2/3/16 at 12:19 p.m., the pantry on the south west unit was toured with the following observations made: Dried coffee stains on the counter top in front of the microwave. There were dried stains of various colors on the interior base of the microwave as well as dried, chunky matter on all interior surfaces, which included the glass turn table where food would have been placed. There was visible dust observed on the front and top surfaces of the microwave. The floor of the pantry was observed to have accumulation of dust, debris and also hairs along the edges of the floor and the wall base. There were 3 individual serving size covered bowls (which matched the facility dishware) with what appeared to be pudding in them. Documentation was lacking on the bowls</p>		<p>been cleaned.</p> <p>Therefrigerator/freezer has had all of the unlabeled, unmarked, undated food ordrink including the bottle of orange juice discarded. The cabinets have beenemptied of any unmarked, unlabeled, undated food including the bread foundduring the survey and the coffee with the scoop in it. These items have been discarded. In the South Hall the freezer/refrigeratorhas been cleaned and all unlabeled, unmarked, undated or expired food or drinkhas been discarded. This includes all ice cream and candy and pop.</p> <p>All residents have the potential tobe affected by this finding.</p> <p>The Housekeeping Supervisor willmonitor all pantry areas and their refrigerator/freezer units 3 days weekly tosee that any food or drink that is unlabeled, unmarked,</p>	

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	<p>as to the contents and a date to identify when it was prepared and expired.</p> <p>On 2/3/16 at 12 p.m., the ICF (Intermediate Care Floor) pantry was toured with the following observations made: inside the refrigerator on the shelves in the door, was a bowl (facility dishware) with a plastic lid covering the contents. There was nothing to identify what the contents of the bowl were or a date on the bowl. The following was observed in the freezer: an opened container of Ice Cream with no open date but a best by date of 4-16-16; a plastic bag, which had a resident's name on it, which contained the following items: an opened container of 1.5 quart of Ice Cream, with a best by date of 10-18-15. There was no date on the container as to when it was opened; another opened container of ice cream, with no date when it was opened and a best buy date of 5-20-16. Another container of ice cream with a resident's name on it was opened but had no date when it was opened on the container and a best by date of 10-22-15. Another opened ice cream container with an open date on it of 11-27-15. Another container of ice cream was opened with no open date but the sell by date was 2-12-16. A container of ice cream with a best if used date of 12-22-16. A container of hand dipped ice</p>		<p>undated or expired isdiscarded. A special effort will be madeto see that any food or drink that belongs to a resident is properly labeledand dated so as to refrain from prematurely discarding it. This monitoring will continue until 4consecutive weeks of zero negative findings are achieved. Afterwards, this monitoring will continue 1day weekly for 6 months to ensure ongoing compliance. After that, randommonitoring will occur.</p> <p>At an in-service being held for allstaff on March 2nd, the facility practice for food being stored in thevarious pantry areas will be reviewed. Thereasons behind labels/names/dates/sealing was discussed. Further, the necessity to keep theses pantryareas and the refrigerators and the microwave ovens therein clean wasdiscussed. The individuals who handlethe food and beverages in</p>	

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	<p>cream date, with an opened date of 8-16-15 which had an "enjoy by 9-1-15." A 48 ounce bottle of prune juice which had been opened was without an open date; two bottles of diet soft drinks (20 ounces), with the initials of RR on them; 2 opened 48 ounce bottles of prune juice with an opened date of 5-25-15, and an expiration date of 9/25/16.</p> <p>4. During an observation of the pantry in the Southwest Hall on 2/10/16 at 11:12 a.m., the following was observed:</p> <p>The microwave was soiled with food splatter.</p> <p>In the upper right cabinet, there was a 1 pound 3.1 ounce opened bag of cookies, not labeled or dated, and an opened 6.2 ounce box of individually packaged fruit treats, not labeled or dated.</p> <p>5. During an observation of the Northwest Hall on 2/10/16 at 11:17 a.m., the following was observed:</p> <p>In the upper cabinet, there was an opened 19 ounce plastic tub of a drink mix, not labeled or dated; an opened 4 ounce metal tin of butter cookies, not labeled or dated; a 4.5 ounce bag of oatmeal raisin cookies with the use by date of 12/3/15; and an opened 8 ounce bag of chocolate</p>		<p>these areas were in-serviced on proper care and handling and labeling of the food and drinks stored there.</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as needed.</p> <p>At the monthly QA meetings the results of the pantry area monitoring will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. The Administrator will address any Action Plan weekly until resolved.</p>	

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	<p>drops not dated.</p> <p>6. During an observation of the pantry in the Skilled Hall on 2/10/16 at 11:30 a.m., the following was observed:</p> <p>The microwave was soiled with food splatters.</p> <p>In the cooler section of the refrigerator/freezer there was an opened 15.2 ounce bottle of orange juice, not labeled or dated.</p> <p>In the upper cabinet there was an opened re-sealed 24 ounce loaf of bread, not dated. The wrapper around the loaf of bread was stamped with best by date of 2/7/16.</p> <p>In the upper cabinet to the left of the door into the pantry a small plastic cup was inside a plastic container of coffee as a scoop.</p> <p>7. During an observation of the pantry in the South Hall on 2/10/16 at 11:38 a.m., the following was observed:</p> <p>In the freezer section of the refrigerator/freezer there was: a 16 ounce container of very strawberry ice cream with the enjoy by date of 9/1/15; a 28 ounce plastic bottle of a strawberry</p>			

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	<p>power drink, not labeled or dated; four opened 1.5 quarts of chocolate/chocolate chip ice cream not dated; a 32 ounce opened container of chocolate chocolate chip ice cream not dated; and an opened 1 pint container of strawberry ice cream not dated.</p> <p>In the cooler section of the refrigerator/freezer there was: a 92 ounce (name brand) chocolate candy bar, not labeled; two 12 ounce cans of beer, not labeled; a 12 ounce can of root beer with the bottom of the can bulging, not labeled; two 12 ounce cans of pop, not labeled; a 7.5 ounce can of pop, not labeled; and a plastic bag containing 3 cans of pop, not labeled.</p> <p>The Administrator was interviewed on 2/11/16 at 9:30 a.m. During the interview she indicated it was the responsibility of the Housekeeping staff to make sure the pantries were clean and food items were labeled and dated.</p> <p>The Administrator was interviewed on 2/11/16 at 12:54 p.m. During the interview she indicated the facility did not have a policy concerning the pantries in the facility.</p> <p>The Registered Dietitian was interviewed on 2/11/16 at 3:04 p.m. During the</p>			

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F 0431 SS=E Bldg. 00	<p>interview she indicated opened items in the pantries should be labeled with the date they were opened. She has also indicated it was good practice for all resident food/beverages stored in the pantries to be labeled with the resident's name.</p> <p>3.1-21(i)(2) 31.-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 biologicals in locked compartments under proper temperature controls, and permit only</p>			

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	<p>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, interview and record review, the facility failed to ensure opened insulin pens, inhalers, nasal sprays, and a vial of heparin (a blood thinner) were labeled with an opened dates. The facility also failed to ensure a vial of Heparin and Over-the-Counter (OTC) medications were labeled with a resident's name and a physician's name. The facility also failed to ensure proper storage of an un-opened insulin pen in 2 of 5 medication carts. The facility further failed to ensure a multi-use medicated treatment solution was labeled with an open date in 1 of 5 treatment carts. This practice affected 13 Resident (Residents' #115, #117, #15, #79, #116, #117, #61, #114, #22, #88, #118, #119, #83).</p> <p>Findings include:</p> <p>1. An observation of the Skilled Unit Medication Cart on 2/10/15 at 2:15 p.m. with LPN #60 indicated the following: One un-opened Lantus Insulin Pen for</p>	F 0431	<p>It is the policy of the facility to see that all medications and biologicals are labeled and stored in accordance with the state and federal drug laws.</p> <p>Residents #115, #117, #15, #79, #116, #117, #61, #114, #22, #88, #118, #119 and #83 have their meds labeled properly.</p> <p>The Lantus pen for Resident #115 has been replaced. Any insulin pen ordered for Resident #115 is properly labeled and dated when opened.</p> <p>Resident #117 has received a new Humalog insulin pen that was dated when opened.</p> <p>The Heparin vial found on the survey has been</p>	03/12/2016

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	<p>Resident #115 with an intact red seal on the cap and was stored in the medication cart.</p> <p>During an interview with LPN #60 on 2/10/15 at 2:16 p.m., the LPN indicated Resident #115's Lantus Insulin was not opened and should have been stored in the refrigerator until the Insulin was opened for use. She also indicated she would need to check with the Pharmacy to have the Lantus Insulin Pen replaced. One opened Lantus Insulin Pen for Resident #115 was not labeled with an opened date.</p> <p>During an interview with LPN #60 on 2/10/16 at 2:17 p.m., the LPN indicated Resident #115's Lantus Insulin Pen was almost full but did not know when it was opened.</p> <p>One opened Humalog Insulin Pen for Resident #117 was not labeled with an opened date.</p> <p>During an interview with LPN #60, the LPN indicated the Humalog Insulin Pen for Resident #117 was opened by the hospital prior to admission to the facility and the hospital had not labeled the Insulin pen with an opened date.</p> <p>One opened 10 milliliter (ml) vial of Heparin (a blood thinner) was not labeled with an opened date. The vial of Heparin was also not labeled with a resident's name.</p> <p>During an interview with LPN #60 on</p>		<p>replaced and is properly labeled.</p> <p>The allergy nasal spray for Resident#79 and the Proventil Inhaler for Resident #116 were replaced and are nowproperly labeled and dated. Both arestored properly.</p> <p>The Advair Inhaler for #117 has beenreplaced and is properly labeled and dated.</p> <p>The Pro Air Inhaler for Resident #61has been replaced and is labeled and dated correctly.</p> <p>The nasal spray for resident #114has been replaced and is labeled and dated and stored correctly.</p> <p>The stool softener for Resident #22has been replaced and is labeled and dated correctly.</p> <p>Resident #88 has had their antacidtablets and their anti-diarrheal replaced. They are both labeled, dated and stored properly.</p> <p>The OTC low dose aspirin forResident #118 and Resident #119 have been replaced and are properly</p>	

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	<p>2/1016 at 2:20 p.m., the LPN indicated she was the nurse who got the vial of Heparin from the facility's EDK (Emergency Drug Kit) for Resident #15 and administered the first dose to the resident. She indicated there was not a pharmacy label on the vial. She further indicated the Heparin vial should be labeled with the resident's name and the physician's name.</p> <p>One opened bottle of Fluticasone Propionate (allergy nose spray) Nasal Spray for Resident #79 was not labeled with an opened date.</p> <p>One opened Proventil Inhaler (prevent bronchospasm) for Resident #116 was not labeled with an opened date. The opened Inhaler was stored in a plastic zip bag with an un-opened Proventil Inhaler from the facility's pharmacy.</p> <p>During an interview with LPN #60 indicated Resident #116's Proventil Inhaler was opened by the hospital prior to her admission to the facility. LPN #60 indicated she stored the unlabeled Proventil Inhaler in the plastic bag with the unopened Proventil inhaler from the facility's pharmacy.</p> <p>One opened Advair Diskus Inhaler (for asthma) for Resident #117 was not labeled with an opened date.</p> <p>Observation of the inhaler indicated 46 doses of 60 doses remained in the inhaler.</p> <p>One opened ProAir Inhaler (for lung</p>		<p>labeled and dated.</p> <p>The Gent/Dakin's Solution that was found during the survey has been discarded and has been replaced and is incorrectly labeled, dated and stored.</p> <p>On the Southwest Unit med cart Resident #83's Proventil Inhaler has been replaced and is correctly labeled and dated.</p> <p>Residents who reside in the facility have the potential to be affected by this finding. The DON/Designee will monitor labeling and dating of all insulin pens, eye drops, inhalers, nasal sprays, multi dose vials and OTC meds at the same time that the supply of the meds is being monitored (See Response for F-224)</p> <p>All nursing staff who administer meds were in-service prior to and will be again on March 2nd, at which time labeling/dating/storage of meds was reviewed (See Response to in-service for</p>	

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	<p>disease) for Resident #61 was not labeled with an opened date.</p> <p>One opened bottle of Fluticasone Propionate (Flonase) Nasal Spray (for allergies) for Resident #114 was not labeled with an opened date. The Fluticasone Propionate Nasal Spray was stored in a plastic zip bag with Nasacort (Triamcinolone Acetonide) Nasal Spray (for allergies), which was not opened. The prescription label on the bag was for the Nasacort Nasal Spray.</p> <p>During an interview with LPN #60 on 2/10/16 at 2:25 p.m., the LPN indicated the Fluticasone Propionate (Flonase) Nasal Spray was stored in the bag with the Nasacort (Triamcinolone Acetonide) Nasal Spray because they were the same medication.</p> <p>One OTC 400 tablet bottle of Stool Softener was not labeled with a resident's name or a physician's name. LPN #60 was observed to label the bottle of Stool Softener with Resident #22's name. The physician's name was not written on the label.</p> <p>One OTC 120 tablet bottle of Regular Strength Antacid Tablets was not labeled with a resident's or a physician's name. LPN # 60 indicated the Antacid Tablets belonged to Resident #88.</p> <p>One OTC 60 tablet bottle of an Antidiarrheal was not labeled with a resident's name or a physician's name.</p>		<p>F-224)</p> <p>At the monthly QA meetings the results of the monitoring by the DON/Designee regarding medication and biological labeling/dating/storage will be discussed and addressed (See Response to F-224)</p>	

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	<p>LPN #60 indicated the antidiarrheal medication belonged to Resident #88. One OTC 120 tablet bottle of Aspirin Low (aspirin) 81 mg was not labeled with a resident's name or a physician's name. LPN #60 was observed to write Resident #118's name on the label. She did not write the physician's name on the label. One OTC 120 tablet bottle of Aspirin 81 was not labeled with a resident's name. Observed LPN #60 write Resident #119's name on the label, but did not label with the physician's name.</p> <p>2. An observation of the Skilled Unit Treatment Cart on 2/10/16 at 4:20 p.m. with LPN #62 indicated the following: One opened 1000 ml Gent (Gentamicin) 1 gram/Dakin's 0.025 % Solution (a wound treatment) was in the bottom drawer of the treatment cart and was not labeled with an opened date. During an interview with LPN #62 on 2/10/16 at 4:25 p.m., the LPN indicated the bottle of Gent/Dakin's Solution should have been labeled with an opened date. She further indicated OTC medications should have a physician's order, and be labeled with the resident's name, the physician's name and an opened date.</p> <p>3. An observation of the Southwest Unit Medication Cart on 2/11/16 at 9:20 a.m. with LPN #63 indicated the following: One opened Proventil Inhaler for</p>			

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	<p>Resident #83 was not labeled with an opened date,</p> <p>During an interview with LPN # 63 on 2/11/16 at 9:25 p.m., the LPN indicated the Resident # 83's Proventil Inhaler was administrated on the evening shift. She indicated the inhaler should have been labeled with an opened date and would order a new inhaler from the pharmacy.</p> <p>4. During an interview with the DON (Director of Nursing) on 2/11/16 at 10:20 a.m.,she indicated insulin, eye drops, inhalers, nasal sprays, any multi-use medications should be labeled with a date when opened. She also indicated OTC medications should have been in the original bottle and labeled with the residents name, the physician's name, medication dose and directions to administer the medication.</p> <p>A review of the current facility policy provided by the DON on 2/11/16 at 11:00 a.m., titled, Medication Storage In The Facility, dated, July 2, 2014, indicated, "...Medications and biologicals are stored safety, securely and properly following the manufacturer or supplier recommendations....Medication labeled for individual residents...." The facility's policy did not provide a policy or procedure about proper labeling of medications.</p> <p>3.1-25(j)</p>			

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F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>			
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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review the facility failed to ensure contact isolation precautions were followed in regards to cleaning the room and passing ice water for 1 of 1 residents with VRE (Vancomycin Resistant Enterococcus) reviewed with isolation precautions. (Resident #14)</p> <p>Findings include:</p> <p>1. On 2/4/16 at 9:12 a.m., Resident #14's room was observed. Resident #14 was observed sitting in his wheelchair in his room. In the doorway of the room, were clear stacked bins with disposable gowns and gloves in them. There was a red sign on the door which indicated to see the nurse before entering the room. The resident's door was opened and the sign was not visible when the room was approached from the main nurses station. However, the sign was visible when the room was approached from the opposite end of the hall. Housekeeper #40 was observed to be cleaning Resident #14's room. Housekeeper #40 had the cart parked outside the room in the hall and was observed to have gloves on but not a gown. The housekeeper was observed to go in and out of the room with gloves on.</p>	F 0441	<p>It is the policy of the facility to see that an Infection Control Program in place designed to prevent the development and transmission of disease and infection.</p> <p>Resident #14 has proper precaution practices in place and utilized when their rooms are cleaned and when ice water is passed. All housekeepers including #40, #34 and #33 are practicing proper technique when it comes to cleaning, entering and exiting Resident #14's room. All nursing staff including CNA #35 are practicing proper technique when it comes to entering and exiting Resident #14's room.</p> <p>All residents have the potential to be affected by this finding.</p> <p>The DON/Designee will monitor 5 staff members from different departments</p>	03/12/2016

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	<p>The housekeeper was observed to take a spray bottle from his cart by unlocking the door of the cart, reaching into his pocket to get keys with gloved hands. The housekeeper was then observed to go into the room and then come out of the room with no gloves on and put the spray bottle back in the cleaning cart by unlocking the compartment with this gloved hands. The housekeeper was also observed to take the broom into the room with the dust pan and sweep the floor. The housekeeper still did not have a gown on. There was a bin outside the door with gloves on top, and gowns were stored in a plastic bin in the room. At 9:16 a.m., the housekeeper came out of the room with gloves on, picked up a bottle and went back into the room after unlocking the locked portion of the cart with the keys that were used to get in and out of the cart several times.</p> <p>On 2/4/16 at 9:21 a.m., Housekeeper #34 moved the housekeeping cart down to the far end of the hall. The mop bucket was still outside of Resident #14's room. At this time, Housekeeper #33 went into the resident's room carrying a large gallon bottle with gloved hands. At 9:24 a.m., Housekeeper #33 was observed in the room cleaning the bathroom. Housekeeper #33 didn't have a gown on while the toilet was being cleaned.</p>		<p>3 days weekly as they enter and exit Resident #14's room or another room where Contact Isolation precautions are in place. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Any infractions will be corrected prior to a breach in technique taking place. Afterwards, the monitoring will take place for 3 staff members 1 day a week. This will continue for a period of 6 months to ensure ongoing compliance. After that, random monitoring will occur.</p> <p>At an all staff in-service held on March 2nd, the following will be reviewed.</p> <p>A. Universal Precautions B. Contact Isolation—When used? C. Demonstration of technique D. Questions and Answers</p> <p>Any staff who fail to comply with the points of the in-service will be further</p>	

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	<p>Housekeeper #33 came out of the bathroom with gloved hands and carried a gallon container with a toilet brush in it, and also carried a bottle with his gloved hands. Housekeeper #33 was observed to walk down the hall, with gloved hands, to the cart which had been moved to the far end of the hall. With gloved hands, Housekeeper #33 reached in his pocket and pulled out the keys to unlock the cart and replace the contents to the locked portion of the housekeeping cart.</p> <p>On 2/5/16 at 10:00 a.m., the clinical record of Resident #14 was reviewed. A urine culture, dated 1/19/16 had the following result: >100,000 orgs (organisms)/ml (milliliter) of Vancomycin Resistant Enterococcus (VRE, a type of bacteria that have developed resistance to many antibiotics). A physician order, dated 1/22/16 indicated "Contact Isolation." A physician order, dated 1-22-16, indicated the following: "Linezolid (antibiotic for treatment of VRE infections)...x (times) 14 days."</p> <p>2. On 2/8/16 at 3:20 p.m., CNA #35 was observed in the hall outside the room of Resident #14 She was observed to go into the room and pick up the resident's water pitcher from his bedside. She was observed to open the top of the pitcher</p>		<p>educated and/or progressively disciplined as necessary.</p> <p>At the monthly QA meetings the results of the DON/Designee monitoring on precautions will be reviewed. Any concerns will have been addressed as observed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. The Administrator will monitor and Action Plan weekly until resolved.</p>	

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	<p>and go into the bathroom and dump out the ice and water. She then brought the water pitcher outside the room and took the ice scoop from the plastic bag and scooped ice into the pitcher. She then replaced the scoop into the plastic bag and went into the bathroom to fill the pitcher with water. She was then observed to replace the top to the water pitcher. She was then observed to leave the room without handwashing.</p> <p>On 2/10/16 at 3:55 p.m., the DON (Director of Nursing) was interviewed. She indicated the facility used the procedure of "Standard Precautions" for "Contact Precautions." At this time, she provided the current procedure for "Standard Precautions" which was dated 7/1/11. This procedure included but was not limited to, the following: "...Standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in the facility...</p> <p>Gloves: wear gloves..when touching...body fluids...and contaminated items...remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient and wash hands immediately to avoid transfer of microorganisms to other patients or environments...Gown: Wear a gown...to</p>			

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	<p>protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of..body fluids...."</p> <p>On 2/11/16 at 11 a.m., a copy of the current facility policy and procedure for "contact precautions" was provided by the DON upon request. The policy was undated and included but was not limited to, the following: "Contact Precautions...are intended to prevent transmission of pathogens spread by direct or indirect contact with the patient or the patient's environment...Staff wear gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE (personal protective equipment) before room entry and discarding before exiting the room...."</p> <p>On 2/11/16 at 11:50 a.m., the DON was interviewed. She indicated the facility Infection Control Program, did not identify contact precautions to be required for VRE infections.</p> <p>3.1-18(b)(1)</p>			

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure comfortable water temperatures, and failed to ensure shower rooms, resident rooms/bathrooms and common areas were clean for 5 of 5 units which had the potential to affect the 83 residents resided in the facility.</p> <p>Findings include:</p> <p>1. An observation of the hot water temperature in room 25's bathroom on 2-3-2016 at 3:00 p.m., indicated after running the hot water for at least 4 minutes, the temperature reached 95.4 degrees Fahrenheit.</p> <p>An observation of the hot water temperature in room 31's bathroom on 2-3-2016 at 12:02 p.m. indicated the hot water temperature reached 93.7 degrees Fahrenheit after running for 3 to 4 minutes.</p> <p>An observation in the South unit's shower</p>	F 0465	<p>It is the policy of the facility to see that the residents have a safe, functional, sanitary and comfortable environment for residents, staff and the public. The water temps in the following areas is within the acceptable parameters per state guidelines Rm #25, Rm #31, South Unit Shower Room and North Unit Shower Room. Further, the Resident Council is satisfied with the water temps as being warm enough. The caulk in Rm #7 by the sink is replaced and the toilet has been cleaned with the rusty screws being replaced/repared. The floor tiles in Rm #7 are now even. The window in Rm #31 has been cleaned. The floors in Rm #31 has been repaired. In the South Shower Room the floor tiles have been repaired/replaced and the floor has been cleaned. The ceiling vent fans have been cleaned and the rust removed in the South Shower Room. The drain and floor have been cleaned. The ceiling has been repaired and ceiling light has been cleaned out. The walls have been cleaned and the missing wall piece has been repaired. The</p>	03/12/2016

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	<p>room on 2-4-2016 at 9:30 a.m., indicated the hot water temperature in the shower after running the water for 4 minutes was 93.4 degrees Fahrenheit before the water temperature started getting cooler.</p> <p>A confidential interview with a resident on 2-4-2016 at 2:49 p.m., indicated the water in the shower room was too cool. The resident indicated the CNAs knew that the water was cool as it would take awhile to get hot.</p> <p>An observation in the North unit's shower room on 2-5-2016 at 10:21 a.m. indicated the hot water temperature in the shower after running the water for 5 minutes was 92.2 degrees Fahrenheit and then dropped to 91.5 degrees Fahrenheit. The hot water temperature continued to drop.</p> <p>An interview with CNA #22 on 2-11-2016 at 10:55 a.m., indicated the hot water was not always warm enough in the showers. The CNA indicated sometimes the water had to run for 20 minutes to get it warm enough. Further interview with the CNA indicated the hot water could start out warm enough and then get cold.</p> <p>An interview with the Administrator on 2-11-2016 at 12:54 p.m., indicated the hot water temperatures should be</p>		<p>toilet has been thoroughly cleaned. The whirlpool has had the caulking replaced around the drain. The laminate in the cabinet has been repaired. In the Northwest Shower Room and the floor have been cleaned and the floor crack has been repaired and the ceiling fan/heater has been thoroughly cleaned. In Rm #209 the floor linoleum and the ceiling have been repaired. In Rm #10 the bedside table handle has been repaired and the bed has been replaced. In Rm #15 the walls have been repaired. In Rm #25 the walls have been repaired in the room and the bathroom and additionally, the floor tiles in the room and the bathroom have been cleaned and replaced as needed. In the South Unit Shower Room the ceiling fan vents were cleaned as well as the floors and walls. In Rm #2 the floor has been cleaned. In the South hallway the floor has been cleaned and the wall carpet near rooms #10, #13, outside the central bath and near the DON office has been repaired. In Rm #16 the bathroom floor has been repaired/cleaned and the door jams have been repaired. The North Shower Room floor has been cleaned, the mirror and counter have been secured, floor vents have been cleaned, and the door has been repaired and cleaned. In the Skilled Unit Shower Room the door frame has been repaired, the floor has been</p>	

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	<p>between 100 degrees Fahrenheit and 120 degrees Fahrenheit.</p> <p>A review of the Resident Council minutes from 6-8-2015 indicated 2 residents complained about the water still being cold in the bathrooms at times.</p> <p>A review of the water temperature log provided by the Administrator for January and February 2016 on 2-11-2016 at 9:57 a.m., indicated temperatures of room hot water done on 1-2, 1-9, 1-15, 1-22, 1-29, 2-5 and 2-10-16 indicated no water temperatures below 100. There were no times recorded and no shower room water temperatures were documented.</p> <p>2. An observation of Room 7 on 2-3-2016 at 11:32 a.m., indicated the caulk along the back of the sink was jagged and dirty. The screws on the toilet base were both rusty and there was dust on the base of the toilet where the screws were. Further observation indicated there was a floor tile positioned in the traffic pattern on the way to the bathroom, which had a corner protruding. This created an uneven surface on the floor.</p> <p>An observation of room 31 on 2-3-2016 at 2:10 p.m., indicated the window to the courtyard was hazy and dirty; the wall</p>		<p>cleaned and the call light has a new pull cord. All residents in the facility have the potential to be affected by this finding. The Administrator and the Maintenance Supervisor have made rounds and have compiled a list of needed repairs in resident rooms, resident bathrooms or shower rooms. This includes: 1. Caulking needs around sinks/tubs 2. Walls in disrepair 3. Cracked/damaged floor tiles—linoleum 4. Doors in disrepair 5. Toilets in disrepair 6. Windows needing repaired 7. Furniture marred/damaged 8. Carpet on walls stained or loose 9. Unsecured sinks/counters/mirrors 10. Call light cords 11. Other</p> <p>There will be a log of all needed repairs. The Administrator and the Maintenance Supervisor will meet and tour the facility weekly to review progress. The goal will be to complete 3-5 rooms weekly. This will continue until all of the initially logged repairs are completed. Routine maintenance will continue during this time including maintenance requests. Additionally, the Maintenance Supervisor will tour the facility weekly to add any concerns to the log. This weekly tour will be ongoing as part of the Preventive Maintenance Program. Further, the Maintenance Supervisor will take and log water temps and</p>	

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	<p>area above the room air conditioner/heater was bubbled along the top edge of the unit. The vinyl floor which ran the width of the room and in the walkway area was raised, which created an uneven surface.</p> <p>An observation South shower room on 2-3-2016 at 10:14 a.m., indicated the shower floor was cracked by the drain, the shower floor was stained/dirty, corners of the shower area were not clean, the ceiling vent fans had layers of dust on the vents and rust was on the fan.</p> <p>The Northwest hall shower room was observed on 2-3-2016 at 10:25 a.m., and the shower room shower was wet, a soiled brief was in the trash, and the shower floor had a crack, at least 2-3 inches in length, near the drain. The ceiling fan/heater had dust coating the vent openings.</p> <p>An observation in room 209-1 on 2-3-2016 at 2:07 p.m., indicated a line of five 12 inch x 12 inch squares of linoleum tile were raised up from the floor, which created an uneven surface and were cracked. Further observation of room 209-1 on 2-10-2016 at 9:20 a.m., indicated at least 6 areas of peeling paints along the edge of the ceiling above the resident's bed.</p>		<p>record. (See Response to F-323 regarding watertemperature monitoring) Additionally, the Administrator andthe Housekeeping Supervisor will tour the facility resident rooms and residentbathrooms and the shower rooms. Theywill log all of the needed cleaning as far as fans/vents/toilets/sinks andfloors. The Administrator and theHousekeeping Supervisor will meet and tour weekly to review progress. The goal will be to complete 5 of the listedareas weekly until completion. This willcontinue until all of the logged areas are completely deep cleaned. Routine cleaning schedules by thehousekeeping staff will continue during this time. Additionally, the Housekeeping Supervisor willtour the facility weekly to monitor for general cleaning and address asfound. This process will beongoing. The Resident Council will beasked if the Maintenance Supervisor and the Housekeeping Supervisor can attendthe Resident Council meetings for the next 3 months and then at the council'srequest for the next 6 months to get input from the council regarding input asto resident satisfaction with water temps and facility cleanliness. An inservice is being held for maintenance and housekeeping staff on March 2nd, the following will be reviewed: A. Resident Rights asrelated to a clean,</p>	

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	<p>An observation of the room 10 on 2-3-2016 at 11:05 a.m., indicated a bedside table in the room had a handle hanging off with one screw missing that would hold it in place. Further observation in room 10 indicated the foot of the bed was banged up with 3 inches of bare wood exposed beneath the top finish. The exposed wood was jagged and rough and was on the outer edge of the footboard that the resident would pass by to go to bed.</p> <p>An observation of room 15-1 on 2-3-2016 at 11:45 a.m., indicated when looking at the resident's bed, the wall to the left of the bed, the top of the bed and to the right of the bed behind the recliner, the walls were banged up with the white drywall material showing.</p> <p>An observation of room 25 on 2-3-2016 at 2:54 p.m., indicated the following: peeling/missing paint on the area around the resident's chair; peeling paint in the bathroom on the wall across from sink and on the wall behind toilet; the tile floor in the bathroom did not go all the way to the wall under the sink; behind the toilet there was a gap that had collected dirt; the grout between the tiles were dark and looked dirty compared to the tile behind the toilet; the corners of the</p>		<p>comfortable, safe, sanitary and functional environment B. Watertemps-tracking/logging C. PreventiveMaintenance Program D. Questions andAnswers Any staff who fail to comply withthe points of the inservice will be further educated and/or progressivelydisciplined as needed. At the QA meetings held monthly theprogress being made on the repairs being made by maintenance as well as thecleaning being accomplished by housekeeping will be reviewed. Any trends will be identified. If necessary an Action Plan will be writtenby the committee, Any Action Plan willbe monitored weekly by the Administrator until resolved.</p>	

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	<p>bathroom had discolored areas and dirt; the floor tile in the room near the bathroom had a long raised area (at least 48 inches long) that has to be walked on or crossed in order to get to the bathroom.</p> <p>An observation of room 305-2 on 2-4-2016 at 8:54 a.m., indicated the bathroom floor had visible dust and hair along the wall edges. A wet paper towel was used to wipe the area with the dirt and hair able to be collected on the wet paper towel.</p> <p>An observation of room 17 on 2-4-2016 at 11:23 a.m., indicated the door frames to the bathroom were scuffed with the bare metal showing, the bathroom floor had dirt and grit in the corners and along the edges of the floor.</p> <p>Further observation in the South unit indicated the edges of the carpet covering the lower 1/2 of the walls in the hallway were observed to be peeling back along the corners and edges of the application. Some of the areas of the carpet along the walls were stained with splatter patterns and drips were observed.</p> <p>An observation of room 305 on 2-4-2016 at 8:53 a.m., indicated the bathroom floor had dust and hair</p>			

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	<p>observed around the perimeter of the room when wiped with a wet paper towel.</p> <p>An observation of the South unit shower room on 2-4-2016 at 9:30 a.m., indicated the ceiling fan vents were caked with dust. The shower floor was not clean and had brown/tan stains throughout.</p> <p>An observation of room 2 on 2-4-2016 at 10:10 a.m. indicated around the perimeter of the floor were dust and bits of debris along the base of the walls and in the corners of the room.</p> <p>An observation in the South hallway on 2-4-2016 at 11:26 a.m., indicated the floor along the baseboards had dirt, grit and was darker than the floor in the center of the hallway.</p> <p>An observation in the South hallway on 2-4-2016 at 1:34 p.m., indicated there was grit and debris stuck to the floor edge by the baseboards.</p> <p>An observation in the South hallway on 2-5-2016 at 8:58 a.m., indicated the carpet pieces were coming loose on the area below the handrails by room 10, 13, the central bath, outside the DON (Director of Nursing) office.</p>			

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	<p>An observation of room 16-3 on 2-5-2016 at 10:18 a.m., indicated in the bathroom along the edges of the floor were visible bits of debris and dust. There were also foot tread marks of a dark color visible beneath the sink, in the area where feet would have been positioned while washing hands. The edges of the door frame and jams had areas of paint missing with the dark metal and other colors of paint exposed beneath.</p> <p>An observation of the North shower room on 2-5-2016 at 10:21 a.m., indicated the shower room floor was not clean as the light tan debris could be scraped off the floor with a fingernail, and there was hair on the shower floor and debris on the drain (a foil cover from a bottle and a bunch of hair). There was a mirror above a counter top in which the corner of the L shaped counter had come apart with the counter unstable and movable. The brace on the left end of the counter had pulled away from the wall. The ceiling vents by the shower and by the sink had dust buildup on the vents slats.</p> <p>An observation of the North unit shower room on 2-8-2016 at 9:48 a.m., indicated no change in the condition of the shower room from 2-5-2016 at 10:21 a.m. The dust on the ceiling and ceiling fans</p>			

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	<p>remained piled up on the vents, the L shaped counter was still pulled away from the wall, the mitered corner of the countertop was still separated and the shower floor was still not clean with a light tan debris on the floor that could be scraped off on a paper towel.</p> <p>An observation of the Skilled unit shower room on 2-8-2016 at 9:52 a.m., indicated the entrance door frame was scratched. The shower floor had black non-skid strips on the shower floor and the floor did not look clean. Using a paper towel, a light tan color could be scraped off the shower floor and a black/brownish color could be wiped up at the shower threshold. Next to the shower, the call light did not have a pull cord.</p> <p>An observation of the South unit shower room on 2 -8-2016 at 12:02 p.m., indicated the 2 ceiling vents were caked with dust and the circular one had rust on it. The shower area drain had hair covering the drain and the shower floor was not clean with tan color stains on the shower floor. The ceiling paint in the shower was peeling and the ceiling light cover had dark pieces of debris on the inside of the cover. Rust stains were observed on the shower wall that ran down the shower wall from the hand rail.</p>			

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	<p>An Environmental tour with the Administrator and Housekeeper #31 on 2-10-2016 from 3:35 p.m. to 3:59 p.m., included to the following observations: the South unit shower room-ceiling vents had dust, toilet fasteners had dirt buildup, edges of the bathroom floor had dirt build up, shower floor not clean, corner wall by the toilet had the lower part of wall missing at base.</p> <p>The North unit shower room had the following observations: the door had 3 notches of missing wood on the door edge that were rough; accumulated dust on the ceiling vents; the shower room floor was not clean and the edges of the floors were not clean; the shelf below the mirror was pulled away from the wall and coming apart at the mitered corner.</p> <p>The Skilled unit shower had a call light by the shower without a pull and the shower floor and threshold were not clean.</p> <p>An interview with Housekeeper #31 during the tour, indicated housekeeping would clean the shower room after each shift's showers and the CNAs (Certified Nursing Assistant) would use a disinfectant on the shower floor after each resident's shower. The housekeeper indicated she could see that the shower</p>			

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	<p>floor had not been scrubbed lately.</p> <p>A review of the "Resident Rights" provided by the Administrator on 2-9-2016 at 9:05 a.m., indicated "...the facility must provide a safe, clean, comfortable, home-like environment...the facility will provide housekeeping and maintenance services...the facility will provide you with comfortable and safe temperature levels...."</p> <p>A current policy, "Water Temperature" dated 2-17-2015 and provided by the Administrator on 2-11-2016 at 12:55 p.m., indicated "...Maintenance will be auditing proper water temperature throughout the building weekly as part of the Preventative Maintenance program...Staff is to report any concerns, whether from family or resident about the temperature of water to Maintenance immediately and fill out a requisition...."</p> <p>3. On 2/3/16 at 11:50 a.m., the shower room was observed in the south hall. The toilet had debris, dust and residue visible on the toilet base by the bolts which attach the toilet to the floor. There was loose debris and dust accumulation along the edge of the floor, next to the wall. The shower area had a dingy, dark residue in the texture pattern on the floor of the shower. Also observed was a rust colored run pattern, which extended from</p>			

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	<p>the grab bar on the wall of the shower, down to the floor. The area on the floor where the textured base of the shower met the floor, had an accumulation of brownish/blackish residue. The free standing whirlpool type bathtub was observed to have caulking missing around the drain area. The cabinet beneath the sink was observed to have the laminate layer missing and/or pulled away from the cabinet beneath. This was an area at least 12 inches long and at least 12 inches high.</p> <p>On 2/3/16 at 1:32 p.m., a confidential resident interview was conducted. The resident indicated the water in her room and the south hall shower room "doesn't get very warm." She indicated the water running for 30 minutes will get barely warm. She indicated the CNA (Certified Nursing Assistant) was aware of the cool temperature of the water because the CNA assisted the resident in the shower. She indicated the CNA had let the water run for along time before she went to the shower and the water was still cold.</p> <p>On 2/4/16 at 9:57 a.m. a confidential resident interview was conducted. This resident indicated the shower room floor on the south hall unit "was filthy." This resident indicated the shower floor was so dirty they "never let my feet touch the</p>			

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	<p>floor."</p> <p>4. On 2/9/16 at 2:53 p.m., the south hall shower room was observed. The toilet was observed to have debris, dust and residue on the toilet base by the bolts which attach the toilet to the floor. There was observed to be loose dust and debris along the edge of the floor, next to the wall. Also, in the shower was observed to be a wad of hair hanging down into the drain, draped over the grates of the drain. The textured surface of the shower floor was also observed to have accumulation of brownish/black buildup in the textured areas.</p> <p>On 2/11/16 at 9:06 a.m., the Administrator provided a copy of the current undated, facility policy and procedure for "Restroom/Shower Room Cleaning Policy/Procedure." The statement included, but was not limited to, the following: "To specifically define cleaning functions in each restroom/shower room. Proper application of listed techniques provides an environmentally clean and safe surrounding (sic) for residents..." The procedure included, but was not limited to, the following: "1. High dusting...dust ledges and surfaces shoulder height and above...high dust tops of lights..fire sprinkler heads, etc...Utilizing a cleaning</p>						

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F 0520 SS=G Bldg. 00	<p>cloth...wipe...all horizontal surfaces...using the appropriate cleaning solution...give special attention to...drain holes...wipe down the tub/shower...clean exterior of the toilet using the appropriate cleaning solution...Spray and wipe top exterior...toilet seat and base...visually inspect restroom/shower room after cleaning to assure all aspects of cleaning are completed...Begin sanitizing floor along baseboards as you enter the...shower room..."</p> <p>3.1-19(f)</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>			

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	<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 QAQI (Quality Assurance and Quality Improvement) Committee failed to implement and/or revise action plans for identified concerns regarding ensuring an incident of alleged abuse was investigated and reported immediately to ISDH (Indiana State Department of Health); ensuring a fall with injury was reported to ISDH; failed to ensure water temperatures were maintained at safe and comfortable levels; failed to assure adequate staffing levels were maintained to meet resident needs timely and safely; failed to ensure call lights were within resident's reach; failed to ensure medications were administered without errors; failed to ensure proper labeling and storage of medication; failed to ensure the environment was clean and was maintained in good repair; failed to ensure infection control practices were followed by staff for an isolation room; failed to ensure hazardous chemicals were out of reach of confused, self mobile residents; and failed to ensure the</p>	F 0520	<p>It is the policy of the facility to maintain a quality assessment and assurance committee to meet at least quarterly to develop action plans to correct any identified deficiencies within the facility.</p> <p>The facility has taken the following concerns through the QAPI process.</p> <ul style="list-style-type: none"> A. Reportable allegations of abuse to the ISDH B. Reporting fall with injury to the ISDH C. Water temperatures—log and track D. Staffing requirements to meet resident needs E. Med errors—less than 5% error rate F. Infection Control Program G. Hazardous chemicals—secured H. Pantries/microwaves/r 	03/12/2016

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	<p>unit pantries' microwaves were cleaned and the pantry items were properly labeled with resident's name and date.</p> <p>Findings include:</p> <p>The QAQI Committee consisted of the Administrator, Medical Director, DON (Director of Nursing), ADON (Assistant Director of Nursing), Safety Director, Dietary Manager, Social Service Director, Environmental Services, all department managers, the pharmacist, and Corporate consultants. The QAQI Committee met monthly and failed to identify and implement action plans for the identified concerns listed above during the annual Recertification survey.</p> <p>An interview with the Administrator on 2/11/16 at 3:05 p.m., indicated the QAQI Committee met monthly. She indicated she became the Administrator of the facility less than a month ago, on 1/13/16 and had not had a QAQI Committee meeting yet. She indicated she had reviewed the previous meeting minutes but was not sure of all of the actions plans currently implemented. She indicated the Medical Director attended the meetings quarterly and received the monthly meeting minutes. She indicated she was not sure how often the Pharmacist attended the QAQI meetings</p>		<p>efrigerators—clean</p> <p>All residents have the potential to be affected by this finding.</p> <p>An inservice was held for the Administrator and the leadership team (Dept. Heads). The inservice was given by a Regional team member and it covered the Quality Assurance program known as QAPI. The following was reviewed:</p> <ul style="list-style-type: none"> A. What is the definition and purpose of QAPI? B. Data collection/forms/tools C. Review results D. Identify areas of concern for deficient practice E. Patterns/Trending F. Action Plan—formation and rollout G. Follow up H. Resolutions substantiated <p>Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined as</p>	

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	<p>but would request the Pharmacist to attend at least quarterly. She indicated the Pharmacist met monthly with the Behavioral Committee. She indicated the Quarterly QA/QI Committee reviewed the prior 3 months data and made decisions on concerns that needed action plans developed or adjusted, determine goals and monitoring and audits of the action plans. She indicated PIP (Performance Improvement Plan) was done every 30 days and the results were to be reported to the QA/QI Committee. The Administrator indicated when goals were met, she would monitor for at least 6 months for compliance. She indicated concerns of residents, families, staff are brought to the QA/QI Committee in various ways; through the department managers, Concern/Grievance forms available in the facility and could be placed in a secure box. Concerns also come for the Resident Council, Social Services and the Corporation Hot Line. The Administrator indicated she knew the QA/QI Committee monitored falls, handwashing, wounds and catheters.</p> <p>Interview with the Administrator on 2/11/16 at 3:35 p.m., indicated she reviewed the QA/QI Committee audits and indicated the committee also reviewed audits for medication storage which was done weekly, Physician orders</p>		<p>indicated. NOTE: A Regional team member will attend the monthly QA meetings for 3 months to ensure that the process is accurate. Any concerns will be addressed as noted. Afterwards, a Regional team member will attend the QA meetings randomly for at least 6 months to ensure ongoing compliance.</p>				

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	<p>and lab results were audited daily. She further indicated the QA/QI Committee had also reviewed staffing turnover, staffing retention and new staff hired.</p> <p>On 2/11/16 at 1:59 p.m., the Administrator provided the current, non-dated, facility policy, titled, The Waters QA/QI Program, which indicated, "...It is the policy of this facility to implement and sustain a QAPQ Program designed to ensure the provisions required by The Patient Protection and Affordable Care Act of 2010.... Quality Assurance and Performance Improvement Program (QAPI) represent our facility's commitment to continuous quality improvement. The program ensures a systematic performance evaluation, problem analysis and implementation of improvement strategies to achieve our performance goals....The QAPI Committee shall look for opportunities for improvement on a continuous basis, and promote an environment of "CQI-Continuous Quality Improvement" environment analyze date monthly to identify opportunities for improvement and potential PIPs. The Committee will make recommendations, and hold a formalized meeting at a minimum of quarterly to review progress and activities of PIP-sub-committees....Oversight of and</p>			

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	<p>analysis of facility data to identify opportunities to improve systems and care...Data may include, but not limited to grievance logs, medical record review, skilled care claims, fall log, pressure ulcer log, treatment logs, staffing trends, incidents and accident reports, quality measures, survey outcomes, etc...."</p> <p>3.1-52(a)(2)</p>			