

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155824	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: November 4, 5, 6, 9, 10, and 12, 2015</p> <p>Facility number: 013302 Provider number: 155824 AIM number: 201281730</p> <p>Census bed type: SNF/NF: 38 Residential: 26 Total: 64</p> <p>Census payor type: Medicare: 10 Medicaid: 12 Other: 16 Total: 38</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on November 22, 2015.</p>	F 0000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on November 4-12, 2015. Please accept this Plan of Correction as Wellbrookes of South Bend's credible allegation of compliance effective, 2015. Wellbrookes of South Bend respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
F 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p>			

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

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

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	<p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to provide showers based on a resident's preference for 1 of 2 residents requiring shower assistance. (Resident #34)</p> <p>Finding includes:</p> <p>During an interview on 11/05/2015 at 11:43 A.M., Resident #34 indicated she was not getting her scheduled showers. The Resident indicated she was scheduled to have a shower on the 3rd shift every Sunday, Tuesday, and Thursday. She indicated they (staff) skipped her showers frequently because there was not enough staff to help her. The resident further indicated when she did not get a shower on her scheduled days, the staff was to offer a shower the following shift or following day. Resident # 34 indicated she had never been offered a shower any of the times her scheduled shower was missed.</p> <p>During an interview on 11/06/2015 at 11:06 A.M., CNA (Certified Nursing</p>	F 0242	<p>Deficiency ID: F _ 0242</p> <p>Plan of Correction Text:</p> <p>1) Resident #34 verbalized she wished to have showers 3 times per week on Monday, Wednesday and Friday early morning.</p> <p>2) All residents have the potential to be affected by this deficient practice. Resident bathing records have been reviewed residents preferences are to be updated pending outcome.</p> <p>3) Director of Health Services or designee re-in serviced nursing staff on following resident bathing preferences and documentation. New admission preferences will be completed within 48 hrs of admission by nursing department. Point Care will be updated to reflect the resident's preferences. DHS/designee will review bathing is being followed per the preferences five days a week for three months.</p> <p>4) QAA will monitor findings</p>	12/10/2015

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	<p>Assistant) #8, indicated the night shift did not always get the night showers completed. She indicated she came in at 5:00 A.M. to help with the remainder of the showers. CNA #8 indicated the Hall Shower sheet had the resident's names listed with their preferred shower day, and as showers were completed, the CNA highlighted the resident's name, indicating the shower was completed. CNA #8 indicated when a resident did not receive their scheduled shower, the resident's name should be added to the Hall Shower sheet for the following day.</p> <p>During an interview on 11/06/2015 at 11:11 A.M., the DON (Director of Nursing) indicated when a CNA completed a resident's shower, the CNA was to highlight the resident's name on the Hall Shower sheet. When a resident did not get a shower at their schedule time, the resident's name was to be entered on the Hall Shower sheet for next day, to be offered at that time. The CNA was to reported the missed shower to the floor nurse, and the floor nurse was to document the reason for the shower omission. The DON indicated showers were also recorded on the Point of Care ADL (Activities of Daily Living), Category Report. She indicated a when bathing type was documented as partial, the resident was washed at the sink in the</p>		<p>monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for three months or until 100% compliance is achieved.</p> <p>Completion Date: 12/10/15</p>				

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	<p>resident's room. The DON indicated resident's documented shower preferences were documented to the 24 Hour Nursing Report and that Resident shower preferences should be honored.</p> <p>On 11/6/2015, at 3:30 P.M., Resident #34's clinical record was reviewed. The most recent MDS (Minimum Data Set), dated 7/29/2015, indicated the diagnoses included but were not limited to, AMI (acute myocardial infarction), hypertension, and anxiety. The resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. The functional status indicated Resident #34 required total assist of 2 persons for transfers and total assist for bathing.</p> <p>The resident's care plans included but were not limited to, ADL care, dated 8/24/2015, related to decreased mobility, with the approach that the resident would like to be showered at least two times a week and bathed on all other days.</p> <p>The 24 Hour Nursing Report Sheet, provided by the DON on 11/09/2015 at 11:56 A.M., indicated the Resident #34's preferred bathing routine was a shower on night shift on Sunday, Tuesday, and Thursday.</p>			

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	<p>The 200 Hall Shower sheet, provided by the DON on 11/6/2015 at 11:15 A.M., indicated in the past two weeks, Resident #34 was scheduled for the following shower dates: 10/25/2015, 10/27/2015, 10/29/2015, 11/01/2015, 11/03/2015, 11/5/2015. Of the scheduled showers, the resident received showers on the following dates: 11/3/2015 and 11/5/2015.</p> <p>From 8/26/2015 to 10/25/2016, Resident #34 documented preference to have showers on Sunday, Tuesday, and Thursday were scheduled on the following dates: 8/27/2015, 8/30/2015, 9/01/2015, 9/03/2015, 9/6/2015, 9/08/2015, 9/10/2015, 9/13/2015, 9/15/2015, 9/17/2015, 9/20/2015, 9/22/2015, 9/24/2015, 9/27/2015, 9/29/2015, 10/01/2015, 10/03/2015, 10/06/2015, 10/08/2015, 10/10/2015, 10/13/2015, 10/15/2015, 10/17/2015, 10/20/2015, 10/22/2015, 10/24/2015. Resident #34 did not receive a shower on any of the dates above.</p> <p>The current document entitled, "GUIDELINES FOR BATHING PREFERENCE," provided by the DON on 11/06/2015 at 3:00 P.M., indicated the purpose was to establish a personal preference bathing routine. The procedure indicated the resident shall</p>			

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F 0323 SS=G Bldg. 00	<p>determine their preference for bathing upon admission. This would include the preferred day of the week, time of day, and type of bathing, tub bath or shower.</p> <p>3.1-3(u)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation interview and record review, the facility failed complete a root cause analysis, assess and develop appropriate interventions for 2 of 3 residents reviewed for unwitnessed falls. This deficiency resulted in a pelvic fracture for Resident #35. (Residents #35 and #65)</p> <p>Findings include:</p> <p>1. During an interview on 11/4/2015 at 2:55 P.M., the DON (Director of Nursing) indicated that Resident #35 had 4 falls in the last 30 days and one fall had resulted in a pelvic fracture and a hospital</p>	F 0323	<p>Deficiency ID: F_0323 Plan of Correction Text: 1) Resident #35 fall care plan has been reviewed and updated. Resident #65 has been discharged. 2) All residents that have had falls have the potential to be affected by this deficient practice. Current residents that have had falls past 30 days have been reviewed for interventions /update of plan of care to ensure interventions are reflective of resident current needs. 3) Nursing staff to be re-inserviced on fall prevention, guidelines of immediate and on-going interventions. Director of Healthcare or designee will monitor interventions of falls for 72 hours to determine appropriateness. The IDT team</p>	12/10/2015

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	<p>stay of 4 days.</p> <p>On 11/9/15 at 10:46 A.M., Resident #35 was observed with O2 (oxygen per nasal cannula) on and communicated without difficulty.</p> <p>On 11/10/2015 at 11:30 A.M., a record review for Resident #35 was conducted. The resident was admitted to the facility on 8/28/15. The Physician orders indicated diagnoses for Resident #35 included, but were not limited to, "...history of falling, heart failure, hypertension...." A "Patient Transfer Assessment Form" from a local hospital, dated 8/28/2015, indicated, "...gets confused...3L [liters] O2 [oxygen]...."</p> <p>The MDS (Minimum Data Set) assessment, dated 9/11/2015, indicated a BIMS (Brief Interview for Mental Status) score was 12 out of 15. The MDS assessment, dated 9/25/2015, indicated a BIMS of 9 out of 15. Both scores indicated the resident was moderately cognitively impaired.</p> <p>On 11/10/2015 at 11:35 A.M., a record review of 6 Fall Events for Resident #35 indicated the following:</p> <p>* Date 9/18/2015 at 8:08 A.M., an unwitnessed fall occurred in Resident</p>		<p>will review each fall in Clinical care meetings to determine root cause of falls and ensure the interventions are appropriate. An incident log will be maintained by DHS or designee to track for any trends and report findings to QA&A. DHS or designee will also review weekly all falls during the Clinical at risk meetings. If any interventions are not appropriate the care plan will be updated to reflect current changes. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is obtained. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved. Completion Date: 12/10/15</p>		

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	<p>#35's bathroom. The resident was found without supplemental oxygen. The neurological checks were partially completed during the 48 hours following the fall. The care plan, updated on 9/18/2015, indicated "Remind/re-educate resident to use call light and ask for assist with transferring and toileting."</p> <p>* Date 9/22/2015 at 4:40 A.M., a fall occurred in Resident #35's bathroom. The fall was unwitnessed. The resident was found without supplemental oxygen. Resident #35 complained of being dizzy and the staff was unable to get a biox (oxygen level) reading. The intervention was to check placement of supplemental oxygen tubing when rounding. The neurological checks were partially completed during the 48 hours following the fall. The care plan was updated on 9/22/2015, to "Please do environmental assessment on rounds for safety paying special attention to my oxygen placement and tubing."</p> <p>* Date 10/5/2015 at 7:20 A.M., a fall occurred in Resident #35's room, fall was unwitnessed and the resident was found without supplemental oxygen. The resident was found to be confused. The intervention was to educate and assist with every care in interaction on supplemental oxygen placement. The</p>			

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	<p>neurological checks were partially completed during the 48 hours after the fall. The care plan was updated on 10/5/2015 to "Educate and assist with every care interaction on O2 placement [to help with placement related to increased confusion]."</p> <p>An IDT (Intra-Disciplinary Team) note, dated 10/-12/2015 at 10:51 A.M., indicated, "Resident continues to remove O2 and suffer periods of increased confusion. Resident was attempting to self transfer and became tangled in O2 tubing. Staff will observe for environmental hazards [including tubing] during rounds and remedy as necessary."</p> <p>* Date 10/9/2015 at 1:00 A.M., a fall occurred in Resident #35's room, fall was unwitnessed and the resident was found without supplemental oxygen and the resident complained of hitting her head during the fall. The progress note, dated 10/9/2015 at 1:00 A.M., indicated, "...Found resident on back with head at the foot at the bed at 12:40 AM yelling for help...at 11:30 PM resident found with O2 on...no oxygen on and on floor...emesis occurred twice..." A Progress note, dated 10/9/2015 at 10:00 A.M., indicated, "Report called to [local hospital] on the patient." Progress note, dated 10/9/2015 at 2:38 P.M., indicated,</p>			

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	<p>"...Hospital called to say that they were sending patient back...." A Progress note, dated 10/10/2015 at 8:38 A.M., indicated, "...Post fall, purple and red bruising from hematoma present. Eye has redness around right eye..." The neurological checks were partially completed before and after the resident's evaluation at the hospital. The care plan was updated on 10/12/2015, to "Offer toileting on rounds, and observe for confusion related to O2 removal by resident."</p> <p>* Date 10/15/2015 at 4:50 A.M., a fall occurred in Resident #35's room, fall was unwitnessed and the resident complained of pain to her left frontal lobe. The fall circumstance indicated a "lg [large] goose egg left frontal lobe." The resident was found without supplemental oxygen. The neurological checks were partially completed during the 48 hours following the fall. The care plan was updated on 10/16/2015, to "Check biox [oxygen saturation]/O2 placement Q [every] 4 hrs [hours] and prn [as needed] at noc [nocturnal]."</p> <p>* Date 10/31/2015 at 1:14 A.M. a fall occurred in Resident #35's room. The Progress note, dated 10/31/2015 at 9:55 A.M., indicated, "...Resident was discovered laying on right side...on floor...Resident has complaint of</p>			

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	<p>tenderness and noted large goose egg on right side of head...Resident also c/o [complaint of] R [right] hip pain...I tried to assist resident to walk with both staff members on each side: resident was unable to bear down full wt [weight] on foot...O2 was not on resident...Resident transferred to ER [emergency room] via stretcher at 0249 [2:49 A.M.]..." The Care plan, dated 11/4/2015, indicated. "Apply alarm to chair and bed. Check for placement and function Q shift."</p> <p>On 11/10/2015 at 1:00 P.M., a record review of a "Patient Transfer Assessment Form", dated 11/3/2015, from a local hospital, indicated, "Nurse Discharge Summary/Current Problem: Pelvic Fx [fracture]-multiple..."</p> <p>The progress notes indicated the following:</p> <p>On 8/31/15 at 3:30 P.M., "It should be noted that resident requires reminder to keep O2 N/C [oxygen per nasal cannula] in place."</p> <p>On 9/1/15 at 6:39 A.M., "Continues to take oxygen off face. Continue to remind to put nasal cannula within nose. Resident is more alert when continuous oxygen is applied."</p>			

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	<p>On 9/2/15 at 6:02 P.M., "Needs reminding at times not to remove O2."</p> <p>On 9/3/15 at 7:10 A.M., "...having a hard time sleeping at night and constantly taking off nasal cannula."</p> <p>On 9/18/15 at 9:02 P.M., "resident continues to take oxygen tube off."</p> <p>On 9/22/15 at 4:38 A.M., "Vital signs noted WNLs [within normal limits] except O2 does not register."</p> <p>On 10/1/2015 at 11:02 P.M., "Pt [patient] does need freq [frequent] reminders/education r/t [related to] O2 TX [treatment] and keeping N/C on."</p> <p>On 10/8/15 at 2:24 P.M., "Resident removes oxygen and needs continued education/reminders to keep oxygen in place. Resident becomes confused when oxygen not in use."</p> <p>On 10/12/15 at 10:59 A.M., "Resident continues to remove O2 resulting in periods of increased confusion."</p> <p>During an interview on 11/10/2015 at 1:42 P.M., the DON (Director of Nursing) indicated, "...after a fall, the first witness needs to ask the resident questions about what they were doing</p>			

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	<p>right before the fall...the nurses should start neurological checks if the fall was unwitnessed or the resident was observed hitting their head in the fall...all neurological checks should be completed which include every 15 minutes times 4, then every hour times 4 and then every 4 hours for 48 hours...the nurse should always put an intervention in place that is relevant to the fall...."</p> <p>2. On 11-6-2015 at 2:58 P.M., a record review for Resident #65 was conducted. Physician orders indicated the diagnoses for Resident #65 included, but were not limited to, Dementia with behavioral disturbance, anxiety, hemiplegia (paralysis to one side of body), encephalopathy, CVA (cardiovascular accident) with left side weakness.</p> <p>The MDS assessment, dated 10-8-2015, indicated the BIMS was unable to be completed by resident and the cognitive status was listed as, "Moderately impaired-decisions poor; cues/supervision required."</p> <p>On 11-6-2015 at 2:58 P.M. a record review of the 5 Fall Events for Resident #65 indicated:</p> <p>* Date 9/15/2015 at 9:58 P.M., an unwitnessed fall occurred in Resident</p>			

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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637
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	<p>#65's room. A Progress note, dated 9/15/2015 at 11:53 P.M., indicated, "...Resident was found on the floor in the middle of his room..." The neurological checks were partially completed for the 48 hours after the fall. The immediate interventions for this fall were "Rest and Lowered bed." An IDT progress note, dated 9-16-2015 at 9:06 A.M., indicated, "...will consult family regarding possible room closer to nurses station when available...move bed against wall on left side, keep in low position and fall mat at bedside..." There was no care plan update available for this fall.</p> <p>* Date 9/17/2015 at 11:40 P.M., an unwitnessed fall occurred in Resident #65's room. A Progress note, dated 9/18/2015 at 12:31 A.M., indicated, "...resident observed on the floor..." The neurological checks were partially completed for the 48 hours after the fall. There was no care plan update was available for this fall.</p> <p>* Date 9/19/2015 at 4:10 A.M., an unwitnessed fall occurred in Resident #65's room. A progress note, dated 9/19/2015 at 12:35 P.M., indicated, "...Resident moved to room [number] this am as part of fall prevention intervention..." The neurological checks for this fall were partially completed for</p>			

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	<p>the 48 hours following this fall. The Care plan was updated, on 9/19/2015, to "Move to room closer to the nursing station so that I can be more easily observed."</p> <p>* Date 9/30/2015 at 6:25 A.M., an unwitnessed fall occurred in Resident #65's. A Progress note, dated 9/30/2015 at 6:25 A.M., indicated, "...found resident sitting on buttocks on padded mattress aside of bed..." The neurological checks were partially completed for the 48 hours following this fall. The Care plan was updated, on 9/30/2015, to "Give resident verbal reminders not to ambulate/transfer without assistance" and "Observe frequently and place in supervised area when out of bed, and visualize on rounds and as often as possible when in bed at noc [night]."</p> <p>* Date 10/9/2015 at 1:44 A.M., an unwitnessed fall occurred in Resident #65's room. The neurological checks were partially completed for the 48 hours following this fall. An update to the care plan, dated 10/6/2015, indicated "Fall mat at bedside on floor when in bed." Another care plan update, dated 10/9/2015, indicated "Parameter mattress to bed for safety" and Tab alarm to chair and bed for safety."</p>			

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	<p>On 11/9/15 at 9:47 A.M., Resident #65 was observed sitting alone in his room with a clip alarm attached to his shirt.</p> <p>During an interview on 11/10/2015 at 1:42 P.M., the DON indicated, "...after a fall, the first witness needs to ask the resident questions about what they were doing right before the fall...the nurses should start neurological checks if the fall was unwitnessed or the resident was observed hitting their head in the fall...all neurological checks should be completed which include every 15 minutes times 4, then every hour times 4 and then every 4 hours for 48 hours...the nurse should always put an intervention in place that is relevant to the fall...."</p> <p>A "Falls Management Program Guidelines" policy, dated as revised on 6/15, was received from the DON on 11/9/2015 at 11:30 A.M. The DON indicated this to be the current policy for falls. The policy indicated, "...Procedure...7. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...."</p> <p>A "Guidelines For Neurological Checks" policy, dated May 2010, was received from the DON on 11/10/2015 at 11:35 A.M. The DON indicated this to be the</p>			

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F 0328 SS=D Bldg. 00	<p>current policy for neurological checks after an unwitnessed fall or fall with head injury. The policy indicated, "...Procedure:...3...Unwitnessed falls should have neuro-checks completed..."</p> <p>3.1-45 (a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure nebulizer inhalation treatments were being given under the supervision of licensed staff for on 1 of 1 residents reviewed for respiratory treatments. (Resident #65)</p> <p>Finding includes: On 11/6/2015 at 2:58 P.M., a record</p>	F 0328	<p>Deficiency ID: F _ 0328</p> <p>Plan of Correction Text:</p> <p>1) Resident #65 has been discharged.</p> <p>2) All residents have the potential to be affected by this deficient practice. Current residents that have nebulizer inhalation treatments were assessed for</p>	12/03/2015

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	<p>review for Resident #65 was conducted. The resident was admitted to the facility on 9/9/2015. The physician orders indicated diagnoses for Resident #65 included, but were not limited to, Dementia with behavioral disturbance, anxiety, hemiplegia (paralysis to one side of body), encephalopathy, CVA (cardiovascular accident) with left side weakness and pneumonia.</p> <p>The MDS assessment, dated 10-8-2015, indicated BIMS (Brief Interview for Mental Status) was unable to be completed by resident and the cognitive status was listed as, "Moderately impaired-decisions poor; cues/supervision required."</p> <p>A Physician order, dated 9-10-2015, indicated, "...ipratropium-albuteral solution [inhaled respiratory medication] for nebulization; 0.5 mg [milligrams]-3 mg/3 ml[milliliters]...Four times a day...."</p> <p>On 11/6/2015 at 7:02 P.M., Resident #65 was observed, alone and in his bed with a nebulizer treatment running. The DON (Director of Nursing) entered the room and indicated, "No, he should not be unsupervised when he is getting his nebulizer treatment."</p> <p>On 11-9-2015 at 11:30 A.M., the DON</p>		<p>ability to self administer inhalation treatments.</p> <p>3) Nursing staff to be re-inserviced on administration of nebulizer inhalation treatments guidelines. Nursing will ensure any assessment related to self administration of medication is completed. DHS/designee will observe three residents per week (or all residents with nebulizer treatments if less than 3) for 3 months to ensure staff following administration guidelines. DHS or designee will report findings to QA&A monthly for 3 months or until 100% compliance is obtained.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p> <p>Completion Date: 12/10/15</p>		

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F 0329 SS=D Bldg. 00	<p>indicated, "He [Resident #65] does not have an assessment to self-administer medication."</p> <p>A current policy "Specific Medication Administration Procedures," effective date: 2/1/10, received from the DON on 11-9-2015 at 11:30 A.M., indicated, "...Nebulizer...L. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer..."</p> <p>3.1-47(a)(6)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and</p>			

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	<p>documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure adequate indication for the use of an antianxiety medication in 1 of 5 resident's reviewed for unnecessary medications. (Resident #14) The facility also failed to ensure a resident drug regime was free of unnecessary drugs related to no diagnosis for antidepressant use for 1 of 5 residents reviewed for unnecessary medications. (Resident 128).</p> <p>Findings include:</p> <p>1. On 11/9/15 at 9:54 A.M., the clinical record for Resident #14 was reviewed. Resident #14 was admitted to the facility on 5/1/15. The diagnoses included, but were not limited to, "...major depressive disorder, muscle wasting and atrophy, dementia, atrial fibrillation, falls...."</p> <p>A physician order, dated 9/13/15, indicated "Ativan [anxiolytics - used for anxiety and insomnia related to anxiety]...0.5 mg [milligrams] oral TID [three times a day]...." A physician order, dated 9/17/15. indicated to discontinue the previous Ativan order and to start</p>	F 0329	<p>Deficiency ID: F _ 0329 Plan of Correction Text: Resident #128 medication (antidepressant) diagnosis was acquired from M.D. Resident #14 ant anxiety medication was reviewed with physician and appropriate diagnosis obtained. 2) All residents on antidepressant/ant anxiety medications have the potential to be affected by this deficient practice. Residents with ant anxiety/antidepressant medications were reviewed for documentation for appropriateness. 3) DHS or designee wills re-inservice nursing on use of antidepressant and Antianxiety medications. DHS/Designee will monitor for behaviors in Clinical Care meetings 5 xs per week to ensure any new medications antidepressants or anti anxiety medications have appropriate diagnosis. DHS or designee will monitor for behaviors. DHS or designee will report findings to QA&A monthly for 3 months or until 100% compliance is obtained. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for 3 months or until 100% compliance</p>	12/10/2015

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	<p>"Ativan...0.25 mg oral...twice a day...watch for s/s [signs and symptoms] of lethargy...."</p> <p>An MDS (Minimum Data Set) assessment, dated 9/3/15, indicated Resident's BIMS (Brief Interview for Mental Status) score was 3 out of a possible 15, severe cognitive impairment. The MDS assessment did not have Anxiety Disorder as a diagnosis. There were no behavior symptoms noted on the assessment.</p> <p>On 11/9/15 at 12:18 P.M., an interview was conducted with the DON (Director of Nursing). The DON indicated all behaviors should be documented in the computer under the "events" tab, "...they are labeled mental health I think...."</p> <p>On 11/9/15 at 1:53 P.M. an interview with the SW (Social Worker) was conducted. The SW indicated "...if a resident has a new behavior it comes up in our morning meeting, we go over the nurses progress notes from the day before. We review the orders to see if there has been any med changes, or if any labs need to be done...then if it is a true behavior we talk about it in our 'CAR' meeting, clinically at risk...we talk about frequency of behaviors, come up with interventions, and possible triggers...</p>		is achieved. Completion Date: 12/10/15		

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	<p>CNA's [Certified Nursing Assistants] and nurses are both responsible for documenting behaviors...they are usually in the progress notes...there should also be a care plan with all the interventions...usually myself and the DON or ADON [Assistant Director of Nursing] collaborate to come up with the care plan...[Resident #14's name] is impulsive, she's having an overall decline...I think there had been some yelling out, but I haven't heard of anything recently...."</p> <p>On 11/9/15 at 2:00 P.M., review of Resident #14's "events" since admission and progress notes up to 9/13/15 indicated no documentation of any type of behaviors.</p> <p>A nursing progress note, dated 9/13/15 at 7:06 P.M., indicated "...at 1730 [5:30 P.M.] resident called for assistance, upon entering room CNA observed Resident with reclining chair all the way forward, sitting on the floor at end of recliner. Vitals obtained, assessment completed, no signs of injuries and no complaints of any pain. MD [Medical Doctor] notified of behaviors and fall. Spoke with [Family members name] POA [Power of Attorney], wants resident to have something for anxiety. Spoke with MD, N.O. [New order] Ativan 0.5 mg TID,</p>			

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	<p>will monitor for sedation...."</p> <p>A IDT (Interdisciplinary team) progress note, dated 9/14/15 at 9:07 A.M., indicated "IDT review - resident has had increased episodes of yelling/calling out. Resident had fall on 9/13/15, observed recliner tilted back and resident on floor in front of chair...Family concerned about anxiety. New order obtained."</p> <p>On 11/12/15 at 11:04 A.M., an interview with the DON was conducted. The DON indicated "...[Resident #14's name] has been here longer than I have. When I came she was already on Ativan. She was having episodes of calling out, and when she got checked on she would say 'I just wanted to make sure you were there' or 'I didn't say anything'. Family thought it was anxiety. There were two instances of calling out when I first got here, but she's not having behaviors anymore...Not since the 2 in August...."</p> <p>On 11/12/15 at 1:30 P.M., an interview with the DON was conducted. The DON indicated "We don't have any behavior tracking for her. No, she does not have a diagnosis of anxiety...."</p> <p>2. On 11/4/15 at 2:43 P.M., clinical record review for Resident # 128 was conducted. The medications included,</p>			

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	<p>but were not limited to Mirtazapine (antidepressant) 15 mg (milligrams), 1/2 tab (tablet) at bedtime. Review of diagnosis's for Resident #128 indicated no documentation of a diagnosis of depression. Review of the Admission MDS (Minimum Data Set) assessment, dated 10/28/15, indicated a score of 03 - minimal depression.</p> <p>The Care Plan, dated 11/4/15, indicated "Resident is at risk for adverse consequences related to receiving antidepressant Medication...." The interventions included "monitor resident's mood and response to medication...."</p> <p>During an interview on 11/9/15 at 12:18 P.M., the Social Services Director indicated "... I believe she is on the anti depressant for sleep... she should have a care plan and a diagnosis if the medication is for sleep or if it's for depression...."</p> <p>During a interview on 11/9/15 at 2:09 P.M., Employee # 6 indicated if a resident is on a anti depressant medication, and scores as depressed on MDS assessment, there should be a care plan and a diagnosis.</p> <p>During a interview on 11/9/15 at 2:17 P.M., the Social Services Director</p>			

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F 0365 SS=D Bldg. 00	<p>indicated "... if a resident comes on a anti depressant , primary care doctor is contacted to obtain a diagnosis, social services or nursing contact the primary care physician to obtain a diagnosis for the medication...."</p> <p>During a interview on 11/9/15 at 2:28 P.M., the Social Service Director indicated the reason she is on the medication is for mild depression ... she was on it from her hospitalization"</p> <p>3.1-48(a)(4)</p> <p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, interview and record review, the facility failed to prepare a pureed diet in a flavorful and consistency with the residents diet order for 1 of 1 residents on a pureed diet. (Resident #65)</p> <p>Finding includes: On 11/6/2015 at 2:00 P.M., during an</p>	F 0365	<p>Deficiency ID: F _ 0365</p> <p>Plan of Correction Text:</p> <p>1) Resident #65 has been discharged.</p> <p>2) All residents have the potential to be affected by this deficient practice.</p> <p>3) Director of Food Services or</p>	12/10/2015

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	<p>observation of the puree process for a seasoned chicken breast, Dietary Aide #5 gathered one seasoned chicken breast and a container with hot water. Dietary Aide #5 placed the seasoned chicken breast into the puree machine, added some of the hot water and started the machine. Dietary Aide #5 indicated, "We do have recipes but I usually just add some hot or cold water to the food and mix it." Dietary Aide #5 then went to look for the recipe, going through 4 books to find the right one. The recipe indicated that chicken broth should be added to the seasoned chicken breast. Dietary Aide #5 turned off the machine and observed the contents. Dietary Aide #5 then put some unmeasured thickener into the machine and mixed the contents for about 30 seconds. The pureed seasoned chicken breast was observed to run off a spoon. Dietary Aide #5 indicated the process was complete.</p> <p>On 11/12/2015 at 9:34 A.M., during an interview, the Dietary Manager indicated, "...Recipes should be followed for pureed diets to retain flavor and maintain consistency as ordered by the physician...she [Dietary Aide #5] does not know the reasoning behind a pureed diet and the importance of correct consistency...."</p>		<p>designee will re-inservice kitchen staff on proper preparation of pureed foods and other forms to meet resident individual needs. DFS or designee will monitor 5 trays per week to include all meals to ensure proper technique is being followed by dietary department. DFS or designee will report findings to QA&A monthly for 3 months or until 100% compliance is obtained.</p> <p>4) QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for 3 months or until 100% compliance is obtained.</p> <p>Completion Date: 12/10/15</p>	

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F 0371 SS=D Bldg. 00	<p>On 11/6/2015 at 2:58 P.M., a record review for Resident #65 was conducted. Physician orders indicated diagnoses for Resident #65 included, but were not limited to, Dementia with behavioral disturbance, anxiety, hemiplegia (paralysis to one side of body), encephalopathy, CVA (cardiovascular accident) with left side weakness. A Physician order, dated 10/15/2015, as the current diet order, "Puree diet with pudding thick liquids."</p> <p>No policy was available related to the puree process.</p> <p>3.1-21(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to store food under sanitary conditions for 1 of 1 kitchens. The facility also failed to serve food under sanitary conditions related to</p>	F 0371	<p>Deficiency ID: F _ 0371</p> <p>Plan of Correction Text:</p> <p>1) Hamburger and beef were</p>	12/10/2015

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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637		
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	<p>handling of glasses', bowls and plates, in 1 of 1 dining rooms.</p> <p>Findings include:</p> <p>1. On 11/4/2015 at 11:00 A.M., a tour of the kitchen was conducted. The following were observed:</p> <p>Hamburger was observed to be thawing with red liquid around it, in the main refrigerator, in a pan, on a shelf. The shelf directly beneath the hamburger contained a box of pre-cooked corned beef thawing with a yellow liquid draining from the box into the pan it was placed in. The Dietary Manager indicated, "The hamburger should be below any pre-cooked products."</p> <p>The dry storage had boxes sitting on the top shelf of the shelving units and were within 3 inches of the ceiling. 2 boxes of plastic cups were sitting on the floor, in the corner of the dry storage room. The Dietary Manager indicated, "These boxes are stacked too high and I think these cups are for the nurses to use."</p> <p>A pan of mushroom gravy, dated 10/31/2015, was observed to be in the main refrigerator. The Dietary Manager indicated, "I usually keep things like this</p>		<p>removed immediately. The gray was thrown away.</p> <p>2) All residents have the potential to be affected by this deficient practice. Staff serving in dining room expected to wash their hands frequently and appropriately. No adverse effects noted.</p> <p>3) DHS & Director of Food Services or designee wills re-inservice nursing & kitchen staff on proper hand washing & handling of glassware. DFS or designee will observe hand washing/handling of glassware in kitchen & dining room five times per week to include all 3 meals for three months or until 100% compliance is obtained.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for 3months or until 100% compliance is achieved.</p> <p>Completion Date: 12/10/15</p>		

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	<p>for a week."</p> <p>On 11/6/2015 at 4 P.M., a policy "Food Labeling Guideline," dated as revised 4/2013, received from the DON (Director of Nursing) as current, indicated, "...Prepared Leftover food items must be discarded within 3 days...Storage Procedures...Gravy/Broth...Beef or Chicken...Refrigerator 1-2 days...." A policy "Storage Procedures," dated as revised 2009, received from the DON as current, indicated, "...Storage of non-food supplies...2. Items are stored at least six [6] inches off the floor and 18 inches from the ceiling...."</p> <p>2. On 11/4/15 between 12:10 P.M. and 12:45 P.M., during the lunch observation in the main dining room the following was observed:</p> <p>At 12:20 P.M., Employee #9 was observed serving a lunch plate to a resident with her her thumb on the inside edge of the plate.</p> <p>At 12:32 P.M., Employee #10 was observed serving a resident a glass of apple juice with her fingers across the top rim of the glass.</p> <p>At 12:33 P.M., Employee #9 was observed serving a bowl of cottage</p>			

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	<p>cheese to a resident with her her thumb on the inside edge of the bowl .</p> <p>At 12:35 P.M., Employee #10 was observed serving a lunch plate to a resident with her thumb on the inside rim of the plate,</p> <p>At 12:36 P.M., Employee #11 was observed serving a resident a lunch plate with his thumb on inside edge of plate.</p> <p>At 12:38 P.M., Employee #9 was observed serving a lunch plate to a resident with her thumbs on the inside edge of plate.</p> <p>At 12:39 P.M., Employee #8 was observed serving a resident a lunch plate with her thumb on the inside edge of the plate.</p> <p>At 12:41 P.M., Employee #11 was observed to carry out a tray from the kitchen, containing a lunch plate and two bowls, he removed the plate and two bowls from the tray with his thumbs on the inside edges and served it to a resident.</p> <p>On 11/9/15 at 11:30 A.M., review of the current policy Titled " Food Production Guidelines Sanitation and Safety " revised 2009, provided by the Director of</p>			

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F 9999 Bldg. 00	<p>Nursing indicated "... 22. Plates, silverware, glasses, etc. are handled so hands do not touch the areas where food or mouth will be placed...."</p> <p>During an interview on 11/12/15 at 9:36 A.M., the DM (Dietary Manager) indicated "...plates should be handled from underneath...fingers should not be on the plate at all...glasses with stems should handled by the stem...bowls should also be handled from underneath...."</p> <p>3.1-21(i)(2)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a</p>	F 9999	<p>Deficiency ID: F_ 9999 Plan of Correction Text: 1) Staff employment records audited. Annual Mantoux testing for all staff will be completed upon hire going forward. 2) No residents were harmed by this deficient practice. 2 associates were found deficiency and have had chest x-rays completed. 3) Payroll will be re-inservice on required documentation prior to the start of associates. All new associates'</p>	12/10/2015

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	<p>department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date, given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three(3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of TB (tuberculin) testing</p>		<p>files will be checked and signed off by the ED prior to starting employment. Executive Director will report findings to QA&A monthly for 3 months or until 100% compliance is obtained. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for 3 months or until 100% compliance is achieved. Completion Date: 12/10/15</p>	

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	<p>and physicals were complete for 2 of 10 employee records reviewed (Employee #14 and #15)</p> <p>Finding includes:</p> <p>On 11/9/15 at 2:30 P.M., review of the employment file for Employee # 14 and Employee #15, dates of hire 8/17/15, indicated that physicals were missing for both Employee #14 and #15 and TB testing was missing from Employee # 14.</p> <p>During an interview on 11/9/15 at 3:55 P.M., Employee #16 indicated "... Employee #14 and #15 are both currently working... we don't have physicals for either of them and Employee #14 doesn't have any TB tests"</p> <p>On 11/10/15 at 1:37 P.M., review of the current policy "Guidelines for TB Results Summary Documentation : Staff and Medical Examinations [Physicals]" indicated " Purpose: To create a TB Result Summary for each staff member upon hire. Procedures 1. Upon hire each employee shall receive a Two Step Mantoux test...Each prospective employee, upon receipt of a conditional offer of employment will be required to undergo a physical examination.</p> <p>3.1-14(t)(1)</p>			

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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 26</p> <p>Residential Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on November 4-12, 2015. Please accept this Plan of Correction as Wellbrookes of South Bend's credible allegation of compliance effective, 2015. Wellbrookes of South Bend respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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R 0273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food was served under sanitary conditions related to the use of gloves. This deficient practice had the potential to affect 16 of 16 residents who ate their meal in the Residential Dining Room.</p> <p>Finding includes:</p> <p>On 11/09/2015 from 11:54 A.M. to 12:25 P.M., during a dining observation, the following was observed:</p> <p>- At 11:54 A.M., Employee #7, was observed preparing a resident meal plate. The employee was wearing a pair of gloves, while holding a hot dog on the dinner plate with the left hand, she cut the hot dog in bite sized pieces using a knife held in the right hand.</p> <p>- At 12:02 P.M., Employee #7 discarded the left hand glove and continued to wear the right hand glove, as she reached into a large bag of shredded cheese with the gloved right hand, took a handful cheese</p>	R 0273	<p>Deficiency ID: F _ 0371</p> <p>Plan of Correction Text:</p> <p>1) Hamburger and beef were removed immediately. The gray was thrown away.</p> <p>2) All residents have the potential to be affected by this deficient practice. Staff serving in dining room expected to wash their hands frequently and appropriately. No adverse effects noted.</p> <p>3) DHS & Director of Food Services or designee wills re-inservice nursing & kitchen staff on proper hand washing & handling of glassware. DFS or designee will observe hand washing/handling of glassware in kitchen & dining room five times per week to include all 3 meals for three months or until 100% compliance is obtained.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for 3months or</p>	12/10/2015

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	<p>and sprinkled it over the hot dog, then handed the plate to CNA (Certified Nursing Assistant) #17 to be delivered to a resident.</p> <p>-At 12:03 P.M., Employee #7 put a fresh glove on the left hand. No hand washing was done before applying the new glove. The same glove remained on the employee's right hand. The employee then opened a plastic container of chicken salad by grasping the plastic lid with her right gloved hand. Employee # 7 got a spoon from the counter top and scooped a spoon full of chicken salad on to a bun that had already been laying open on a plate at the time this observation began. She carried the plate to the warmer table and grabbed a handful of french fries out of the warmer try and put them on the meal plate. Employee #7 put the meal plate down on the counter and picked up a meal ticket from the counter with the right gloved hand, and looked at the order. Then the employee picked up a handheld radio and put it back down, using her right hand. Then the employee picked up the plate and gave it to CNA #17 to deliver to a resident.</p> <p>- At 12:09 P.M., Employee #7 picked up 3 meal tickets from the counter to read them. Wearing the same gloves, she</p>		<p>until 100% compliance is achieved.</p> <p>Completion Date: 12/10/15</p>	

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	<p>picked up a meal plate, reached her left hand into an open bag of hotdog buns and put a bun on the meal plate. She used tongs to get a hot dog out of the warmer tray and put the hotdog on the bun. She used a scoop from the hot dog chili sauce and spread sauce on the hot dog. While holding the plate with the left hand, she reached to same gloved right hand into the bag of shredded cheese and applied the cheese to the chili hot dog. The employee filled the rest of the plate and gave it to CNA #17 to deliver to a resident.</p> <p>-From 12:13 P.M. to 12:20 P.M., Employee #7 looked at meal tickets.</p> <p>-At 12:20 P.M., Employee #7 prepared another plate while wearing the same gloves. She reached into the hot dog bun bag and put a bun on a dinner plate. Then she used tongs to put a hot dog onto the bun, and used a scoop to put chili sauce on the hot dog. With the same right gloved hand the employee reached into the shredded cheese bag and put a handful of the cheese on the hot dog. Employee #7 gave the plate to Employee #17 to deliver to a resident.</p> <p>During an interview on 11/09/2015 at 12:27 P.M., the DON (Director of Nursing) indicated that employees should</p>			

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R 0349	<p>never handle food directly with their hands. If gloves are worn to reach into a hot dog bun bag, or a bag of cheese, the Employee must discard the gloves, wash their hands, and put on fresh gloves. The DON indicated employees should never wear the same gloves to handle different foods or resident plates.</p> <p>During an interview on 11/12/2015 at 11:10 A.M., the Food Service Director indicated employees should never handle food with gloves that previously handle any other food or and other item. Employees should always wash hands after taking gloves off and before putting a new pair on.</p> <p>On 11/12/2015 2:10 P.M., the policy entitled 410 IAC 7-21 Section 36 - Personnel Hygienic Practices (Retail Food Establishment Sanitation Requirements) (no date), which was provided by the DON, was reviewed. Bullet #5 indicated that gloves must be maintained in an intact, clean, and sanitary condition if they are used in direct contact with food.</p>			
	410 IAC 16.2-5-8.1(a)(1-4)			

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Bldg. 00	<p>Clinical Records - Noncompliance</p> <p>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on observation and interview the facility failed to maintain complete clinical records on residents for 3 of 7 resident records reviewed. (Residents #130, #132 and #133).</p> <p>Finding includes:</p> <p>On 11/9/15 at 9:10 A.M., a clinical record review was conducted for Resident #133. The clinical record indicated Resident #133 was admitted on 11/6/15 and an admission weight had not been recorded in the chart.</p> <p>On 11/9/15 at 9:45 A.M., a clinical record review was conducted for for residents #130 and #132. The clinical records indicated Resident #130 was admitted on 12/15/14 and Resident #132 was admitted on 3/6/15. These residents had not received a 1st and 2nd step tuberculin testing.</p>	R 0349	<p>1) Resident 130 weight was obtained. Resident 130 & 136 Mantoux process has been started. 2) All residents in Assisted Living records were reviewed and deficiencies noted were corrected at that time.3) Licensed nurses were re-inserviced on 1st and 2nd step mantoux and obtaining admission weights. DHS or designee will monitor all new admissions to AL to ensure proper weights obtained and Mantoux process is being followed. DHS or designee will report findings to QA&A monthly for 3 months or until 100% compliance is obtained.4) QA&A will montior monthly for any trends and make recommendations to the Plan of correction as needed. QA&A will monitor monthly for 3 months or until 100% compliance is obtained.5) Completion date: 12/10/15</p>	12/10/2015			

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	<p>During an interview on 11/9/15 at 11:00 A.M., Registered Nurse #12 indicated "... all residents upon admission should have a 2 step tuberculin testing and admission weights...."</p> <p>Review of the current Assisted Living Guidelines " Chest Xray and Mantoux Testing and Weights," dated 10/2012 and December 2010, provided by the Corporate Clinical Support Nurse, indicated "... Residents should have a Mantoux test: ...b. Indiana- within 3 months of admission if proof of previous testing or upon admission... 2. Mantoux testing should be a two step process"</p>				