STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155029		10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

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F 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00156782 and IN00155910. Complaint IN00156782-Unsubstantiated due to lack of evidence. Complaint IN00155910-Substantiated. Deficiencies related to the allegations are cited at F241. Survey dates: October 22, 23, 24, 27, 28, 29, and 30, 2014 Facility number: 000012 Provider number: 155029 AIM number: 100274900 Survey team: Karina Gates, Generalist-TC Beth Walsh, RN Tom Stauss, RN Census bed type: SNF/NF: 95 Total: 95 Census payor type: Medicare: 11 Medicaid: 69 Other: 15	F 000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after November 21st, 2014. We respectfully request a desk review in lieu of a post survey revisit.	

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

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

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	Total: 95 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on Novenber 6, 2014 by Cheryl Fielden, RN.			
F 156 SS=A Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and			

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	inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident			

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	abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on interview and record review, the facility failed to issue a liability and appeal notice, when required, to 1 of 3 discharged, Medicare beneficiaries reviewed for appropriate liability and appeal notices. (Resident #59) Findings include: The clinical record for Resident #59 was reviewed on 10/26/14 at 1:30 p.m. She was admitted to the facility on 5/28/14 from the hospital, on Medicare. The liability and appeal notice for Resident #59 was requested from the Social Services Director (SSD) on 10/26/14 at 2:00 p.m. The notice was not provided. An interview was conducted with the	F 156	**F 156 (a) Notice of rights, Rules, Services, and Charges** **1.whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;** The resident that was affected nolonger resides in the facility **1.How will you identify other residentshaving the potential to be affected by the same deficient practice and whatcorrective action will be taken?** ·All residents receiving Medicare coverage havethe potential to be affected by this alleged deficient practice. ·The Social Service Director or designee willin-service the Social Service department and business office manager on theNOMNC procedure. ·Residents who were discharged in the last 14days	11/29/2014

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	SSD on 10/27/14, at 11:00 a.m. She indicated, "We don't have a notice for her. I don't think she got it. She should have received the notice 48 hours prior to her last day of therapy. She discharged home on 7/29/14. She was on day 62 of (Medicare) services." The SSD provided a copy of the Checklist/Instructions for Issuing a Notice of Medicare Non-Coverage (NOMNC)/Determination on Continued Stay policy, on 10/27/14 at 3:07 p.m. It indicated, "When should notices be given? 1. Part A-End of Part A covered level of care with benefit days remaining. 2. Part B-End of all Part B therapy services....NOMNC form must be issued no later than two days (48 hours) before the proposed end of services." 3.1-4(f)(3)		were audited by SS or designee to ensure proper notification regarding Medicarecuts. If these residents were notnotified appropriate action was taken per policy. **1.What measures will be put into place orwhat systemic changes will you make to ensure that the deficient practice doesnot recur?** ·The Social Service Director or designee willin-service the Social Service department and business office manager on theNOMNC procedure on or before 11/29/14 ·The IDT team will meet weekly to review allresidents who are receiving Medicare coverage. During this weekly meeting the team will discuss all residents who arepending discharge of services and in need of NOMNC letters. These letters willthen be created and presented to the residents and or family members fornotification and signatures. **1. How the corrective action will be monitored toensure the deficient practice will not recur i.e. what quality assuranceprogram will be put into place** ·Executive Director/Designee will completethe Medicare cut letter CQI weekly X4 weeks, bi weekly X 2 months, monthly x 4months and quarterly thereafter. ·The Medicare cut letter CQI audit tool will bereviewed monthly	

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			by the CQI Committee for six months after which the CQI teamwill re-evaluate the continued need for the audit. If a 100% threshold is notachieved an action plan will be developed. ·Deficiency in this practice will result indisciplinary action up to and including termination of the responsibleemployee. ·Date of Compliance 11/29/2014.	
F 157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights			

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	under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to adequately notify a Physician of a Resident's Emergency Room visit for 1 of 1 residents reviewed for Pre Admission Screening/Annual Resident Review (PASRR). (Resident #36) Findings include: The clinical record for Resident #36 was reviewed on 10/28/14 at 10:15 a.m. The diagnoses for Resident #36 included, but were not limited to, mental retardation, seizure disorder, diastolic heart failure, and schizoaffective disorder. A Progress Note from Resident #36's dialysis center, dated 10/11/14 at 10:20, indicated, "Pt [patient] experienced allergic reaction to Vanc. [vancomycin-antibiotic] MD paged, 50mg [sic-milligrams] Benedryl IV [intravenous] given and pt sent to ER. ER notified. No respiratory distress noted. Facial edema and hives present. Pt A&O [alert and oriented] x3 [sic]. Pt sent to ER with transport company	F 157	**F157 Facility respectively requesting face to face IDR for F157 as facility disagrees with scope and severity assigned tothis deficiency. 1: What correctiveaction(s) will be accomplished for those residents found to have affected bythe deficient practice?** ·In regards to Resident # 36 all nurses were in-serviced on adequately notifying a physician. Vancomycin allergy was added to Resident # 36's plan of care. For Resident #36, Physician issued order for Vancomycin allergy. **2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken** ·All residents who transferred to the hospital from an outside appointment have the potential to be affected. ·Licensed nursing staff was in-serviced by Clinical Education Coordinator on November 11th, 2014, regarding adequately notifying physician of transfer to hospital from appointment. ·DNS/Designee will complete an audit of all residents who were	11/29/2014

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	immediately post dialysis." A review of the ED [Emergency Department] Provider Note, dated 10/11/14 at 11:58 a.m., indicated, "...female who presents to the ED with an acute allergic reaction just prior to arrival. Pt was escorted via EMS [emergency medical service] who administered 50 mg of benedryl IV en route. There is still facial swelling and itching of upper ext [extremity-arm] upon arrival. Pt states she was in dialysis and they were concerned about shunt [sic] infection and was given IV Vancomycin [sic]. As it [vancomycin] was completed, the symptoms developed ....No previous known allergy to Vancomycin [sic] ...." A review of Hospital Encounter Visit note, dated 10/11/14, indicated, "Your diagnosis was DRUG REACTION, INITIAL ENCOUNTER...." The Discharge Instructions indicated, "...You have been seen for an unusual reaction to a medicine. Do not take vancomycin! You seem to be having an allergic reaction to a medicine. Stop taking the medicine. Tell your regular doctor that you are allergic to the medicine....In the future, list this medicine when you are asked about medicines you are allergic to...."		sent to the ER in the last 30 days to ensure the physician was appropriately notified. **3: Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.** ·Licensed nursing staff was in-serviced by Clinical Education Coordinator on November 11th, 2014, regarding adequately notifying physician of transfer to hospital from appointment. ·DNS/Designee will review the charts of any residents transferred to the emergency room from an outside appointment to ensure attending physician is adequately notified by reviewing daily activity report. **4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place** ·DNS/Designee will complete the Change of condition CQI weekly X4 weeks, bi weekly X 2 months, monthly x 4 months and quarterly thereafter. ·The change of condition CQI audit tool will bereviewed monthly by the CQI Committee for six months after which the CQI teamwill re-evaluate the continued need for the audit. If a 100% threshold is notachieved an action plan will be developed. ·Deficiency in this practice will result indisciplinary action up to and including termination of the	

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	A Progress Note, dated 10/11/14 at 1:23 p.m., indicated, "Resident returned from dialysis upon returning resident in room [sic] CNA called this writer to room and found resident on floor having a seizure which lasted for 3 minutes [sic] resident alert at this time [sic] able to tell me her name and date of birth, complete assessment done resident [sic] writer noted upper lip swollen no bleeding or bruising noted [sic] resident fistula [dialysis access site] dressing intact with bruit and thrill, resident seen at hospital prior to returning to facility for inflamed psoriasis [sic] received script for Benedryl [sic] family and Md notified...." During an interview with the Dialysis Preceptor Manager (Dialysis RN #11), on 10/28/14 at 11:34 a.m., Dialysis RN #11 indicated there was no indication in Resident #36's dialysis clinical record that the facility called to follow up regarding the ER visit and the initial reason/order for the prescribed vancomycin. On 10/28/14, at 12:23 p.m., the Director of Nursing Services (DNS) indicated the dialysis center was just contacted to verify if the vancomycin was an allergic reaction or a drug interaction. The documentation/verification of follow up related to possible allergy to vancomycin,		responsibleemployee. ·Date of Compliance 11/29/2014.	

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	follow up for initial reason/order of vancomycin, and Physician notification of ER visit related to a vancomycin reaction was requested at this time. At 1:05 p.m., on 10/28/14, Dialysis RN #11 also indicated the facility just called her about 15 minutes ago to clarify the situation regarding the ER visit for a vancomycin reaction. During an interview with the DNS, on 10/28/14 at 2:33 p.m., she indicated the nurse "receiving the resident" from the ambulance company was in charge of reviewing the hospital paperwork, including the discharge instructions. The DNS indicated Unit Manger #8 wrote the above 10/11/14 facility Progress Note. The DNS indicated Unit Manager #8 indicated in the Progress Note that Resident #36 was seen at the ER for psoriasis because the Ambulance Service Log indicated, "...dispatched to [name of hospital] for transport. responded non emergent. arrived to [age/description of Resident #36] standing by nurses [sic] station in emergency department. patient report obtained from rn [sic]. patient came in for itchiness after dialysis. patients [sic] psoriasis was inflamed...." The DNS also indicated the facility might've faxed something to the primary physician regarding the ER visit related			

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	to the reaction to vancomycin. During an interview with the DNS, on 10/29/14 at 9:55 a.m., the DNS indicated the Unit Manager #8 called Physician 7's office regarding 10/11/14 ER visit related to the vancomycin reaction and Physician 7's office would be happy to provide further information. The name of the Physician 7's Office Triage Contact (LPN #14) was provided at this time. On 10/28/14, at 10:07 a.m., during an interview with the Physician #7's Office Triage Contact (LPN #14), LPN #14 initially indicated their office was informed Resident #36 was at dialysis and went to the ER. LPN #14 further indicated Physician #7's Office was notified on 10/11/14 after Resident #36 came back to the facility from the ER and the facility told us, [Physician #7's Office] Resident #36 was at the ER for itching and the facility was unsure why Resident #36 was itching. The Hospital Discharge Instructions from 10/11/14 were relayed to LPN #14 at this time and LPN #14 indicated, "I can't tell you for sure if we [Physician #7's Office] were told about the vancomycin. We did not know she was allergic to vancomycin. I don't know if they informed us of that immediately. [Name of Physician #7] was made aware on 10/11/14 that she			

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	[Resident #36] went to the ER." On 10/30/14, at 12:49 p.m., during a phone conversation with Physician #7, Physician #7 was read the above Discharge Instructions/ER Provider Note from the 10/11/14 ER visit. Physician #7 indicated she was not provided the Discharge Instructions from the 10/11/14 ER visit. Physician #7 also indicated she was not made aware of Resident #36's facial swelling after the vancomycin was administered in dialysis and that was why Resident #36 was sent to the ER. Physician #7 further indicated people can develop allergies to medication that they previously took without incident. Physician #7 indicated she was told to follow up on Resident #36 for seizure activity on 10/11/14, during Physician #7's 10/28/14 facility visit. Physician #7 also indicated based on the information just provided about Resident #36's facial swelling and the ER Discharge Instructions, related to the allergic reaction to vancomycin, Physician #7 would consider vancomycin as an allergy for Resident #36. During a conference call with Physician #7, the DNS, and the Administrator, on 10/30/14 at 2:18 p.m., Physician #7 indicated she did not have "full knowledge" of the 10/11/14 ER visit.			

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	Physician #7 also indicated if she saw something in bold typeface listed on hospital Discharge Instructions, she would've followed up on it. Physician #7 indicated if the Discharge Instructions were relayed/provided to her office on 10/11/14, her office probably would have sent someone out sooner to see Resident #36, than Physician #7 was able to. Physician #7 further indicated there was some miscommunication between the facility and her related to the ER visit, the vancomycin reaction, and the 10/11/14 seizure. Physician #7 indicated now that she was provided the "full story," Physician #7 wanted vancomycin listed as an allergy for Resident #36. After the conference call with Physician #7, on 10/30/14 at 2:23 p.m., the DNS indicated she had text messages from Physician #7 that day, contradicting what Physician #7 just said. The DNS indicated the text messages were at a time before the above 12:49 p.m. phone conversation with Physician #7. The DNS further indicated the text messages indicated the facility notified Physician #7 there was still a concern about the reaction to vancomycin and Physician #7 indicated in her text response, she did not believe Resident #36 had a reaction to that medication. When the DNS was queried if the miscommunication was			

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	that Physician #7 thought the concern was Resident #36's seizure on 10/11/14 was caused by vancomycin, the DNS had no response. 3.1-5(a)(2)			
F 247 SS=D Bldg. 00	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to notify a resident she would receive a new roommate for 1 of 2 residents reviewed of 2, who met the criteria for admission, transfer, and discharge. (Resident #41) Findings include: An interview was conducted with Resident #41 on 10/22/14, at 2:45 p.m. She indicated she received a new roommate within the last 9 months, but was not given prior notice. She stated, "They just walked in with my new roommate, and never told me beforehand." An interview was conducted with the SSD (Social Services Director) and SSA (Social Services Assistant) on 10/27/14, at 11:10 a.m., regarding the facility	F 247	**F247-Right to notice before room change** **1. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;** ·Resident#41 was notified of her new roommate and informed that she will be notified ofany new roommate changes prior to the new roommate arriving. **2. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken;** ·Allresidents who receive a new roommate have the potential to be affected by thealleged deficient practice. ·Executivedirector in-serviced social services staff on 11/18/14 on the intra facility transfer policy to ensureunderstanding and promote compliance	11/29/2014

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	practice for notifying a resident, when they receive a new roommate. She indicated, "The resident is informed by the nurse, aide, Admission Director, or maybe social services. More consistently, it's our Customer Care Coordinator (CCC) or Admission Director." She indicated she was uncertain as to how much notice the resident received, prior to receiving a roommate. The SSA stated, "Usually a couple of hours before." An interview was conducted with the SSD, SSA, and CCC on 10/27/14 at 11:40 a.m. The SSD indicated, "It looks like (name of Resident #174) came into (name of Resident #41's) room on 10/20/14. I don't see any verification she was notified or given a heads up in the progress notes. I don't know anywhere else it would be noted. We don't do paperwork when someone receives a new roommate. I'll go to (name of the Administrator), and see if we have a policy on notifying a resident, when they get a new roommate." The SSD briefly left the room, returned, and stated, "We have no policy for notifying a resident who receives a roommate from the outside. (Name of Resident #174) came on Monday, 10/20/14 at 2:30 p.m. The SSD and CCC agreed Resident #174's return to the facility was discussed at the		·Anytimea resident is moved within the facility or a new resident is placed within thefacility, social services director or their designee will notify currentresident in room and will follow facility intra-facility transfer policy. ·Anaudit will be conducted on all residents who have had a new roommate in thelast 30 days to ensure appropriate notification occurred. If notification did not occur appropriatelythe residents will be informed that with future room changes the resident willbe notified in advance of receiving a new roommate. **3 whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;** ·Whena resident is moved within the facility or a new resident is placed within thefacility, the social services director or their designee will notify the currentresident in room in advance of the new resident being admitted to the room and thesocial service dept will follow facility intra-facility transfer policy. ·Executivedirector will in-service social services staff on intra facility transferpolicy to ensure understanding and promote compliance on or before 11/29/14 ·Thesocial services director will review each room change and or admission toensure the resident currently in the room is notified of	

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	Monday Morning Meeting, on 10/20/14. The SSD indicated, "We knew (name of Resident #174) was coming back on 10/20/14, but not what specific time. There was time to tell (name of Resident #41) she was getting a new roommate, and she may have been told, but clearly, it's not documented. The SSD, SSA, and CCC agreed that none of them spoke with Resident #41 about getting a new roommate on 10/20/14. The Resident Admission Record for Resident #174 indicated she was admitted to the facility on 10/20/14, at 2:32 p.m., into Resident #41's room. The Intra-Facility Transfers policy was provided by the SSD on 10/27/14, at 11:40 a.m. It indicated, "The receiving roommate and or legal representative will be notified of the new roommate prior to the move. This notification will be documented in the medical record." During an interview with the Administrator on 10/27/14 at 12:45 p.m., he indicated he didn't know why the facility had no policy to address resident notification of a new roommate from the outside. 5-1.2(m)		a new roommateappropriately. This information will bedocumented in the medical record. ·SSDwill bring list of previous days room changes/planned room changes to ensurethat roommate was properly notified in progress notes. **4 howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·The Social Services Director or Designeewill complete the Social services documentation CQI (intra-facility transfersection) CQI weekly X4 weeks, monthly x 5 months and quarterly thereafter. · The Social services documentation CQI(intra-facility transfer section) CQI will be reviewed monthly by theCQI Committee for six months after which the CQI team will re-evaluate thecontinued need for the audit. If a 100% threshold is not achieved an actionplan will be developed. ·Deficiency in this practice will result indisciplinary action up to and including termination of the responsibleemployee. ·Date of Compliance 11/29/2014	

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F 253 SS=E Bldg. 00	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to provide a homelike environment/bathroom for 5 of 37 residents reviewed for homelike environment. (Resident #'s #20, #45, #66, #148, #173) Findings include: During a random observation, on 10/23/14 at 10:56 a.m., of Resident #20 and #66's bathroom, the baseboard trim was pulling away from the wall and several hand length gouges were observed on the bathroom wall. A large rust colored ring was observed around the toilet base. The bathroom door was observed with arm length gouges along the bottom half of the door and the bathroom door frame was observed with hand length gouges on the door frame. During a random observation, on 10/24/14 at 11:30 a.m., of Resident #173's bathroom, a large rust colored ring was noted around the base of the toilet	F 253	**F-253 Housekeeping Maint Services** **1. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;** ·Inresident # 20 and #66s bathroom the baseboard trim and gouges in the wall wererepaired. The rust color ring around the toilet was cleaned; the gouges in thebathroom door and door frame were repaired. ·Inresidents 173's bathroom the rust color ring was cleaned around the toilet, thecaulk around the toilet was repaired, the toilet seat was replaced ·Inresidents 45 and 148 bathroom the wall tiles were repaired, the gouges outsidethe bathroom and the gouges near the resident's window were repaired **2. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken;** ·All residents residing in the	11/29/2014

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	with the caulk peeling away from the toilet base. The toilet seat was observed to have peeling paint coming off of the back of seat fixture. During a random observation, on 10/24/14 at 11:33 a.m., of Resident #45 and #148's bathroom, the bathroom wall tile was noted to be peeling on the left and right wall of the bathroom. Several tiles on both walls had the white tile coating peeling away from the tile, exposing green tile underneath. The walls on the outside of the bathroom had multiple finger length gouges along the wall and the wall next to the window also was observed with multiple finger length gouges on it. During an interview with Resident #45, on 10/24/14 at 11:35 a.m., Resident #45 indicated the bathroom tile and room walls had looked like what was described above since he moved into the room. During a random observation of the rooms above, on 10/27/14 at 10:20 a.m., the bathrooms/walls were observed in the same condition as described above. On 10/27/14, at 10:25 a.m., Resident #173 indicated the bathroom looked like it was described above since he moved in. Resident #173 further indicated the		facility have thepotential to be affected by this alleged deficient practice. ·The SDC or designee will educate all staff onreporting any non homelike environmental observations to the facility supervisorfor repair on before 11/29/2014. ·An audit of all rooms and hallway was conductedby the maintenance supervisor and repairs are scheduled to be made to ensurethe rooms present as a homelike environment. **3. what measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur**; ·The SDC or designee will educate all staff onreporting any non homelike environmental observations to the facility supervisorfor repair on before 11/29/2014. ·The facility department heads will completedaily rounds Monday thru Friday and report any environmental findings in theafternoon CQI meeting. The weekend housesupervisor will make rounds on Saturday and Sunday and report abnormal findingsto the executive director. These findings will be logged in the maintenancerepair log and audited daily to ensure they are completed. ·The facility has created a	

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	peeling paint on the toilet seat and the rust colored ring/peeling caulk around the toilet base did not provide a homelike environment for him. A tour of the Resident's bathrooms listed above was completed with the Administrator and Maintenance Director, on 10/27/14 at 12:50 p.m. The Administrator indicated at this time, the 3 bathrooms observed did not provide a homelike environment for the Residents residing in the room. The Administrator further indicated the Floor Technician had been on leave for the past 3 weeks and that might explain the rust colored rings around the toilet bases. The Administrator also indicated the wall gouges/marks and peeling paint can be fixed and these rooms were scheduled to be renovated with the new budget. 3.1-19(f)(5)		maintenance repairand evaluation schedule. The maintenancedirector will evaluate facility areas on a scheduled basis ensuring theypresent as a homelike environment. Itemsidentified that are in need of repair will be logged and scheduled for repair. **4 Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·An Environmental CQI audit tool will becompleted for six months with audits being completed once weekly for one monthand monthly for 5 months by the maintenance supervisor or designee. ·The Environmental CQI audit tool will bereviewed monthly by the CQI Committee for six months after which the CQI teamwill re-evaluate the continued need for the audit. If a 95% threshold is notachieved an action plan will be developed. ·Deficiency in this practice will result indisciplinary action up to and including termination of the responsibleemployee. ·Date of Compliance 11/29/2014.	
F 279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise			

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	the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review, the facility failed to develop a care plan with a resident's preference for dress for 1 of 4 residents reviewed for dignity. (Resident #82) Findings include: The clinical record for Resident #82 was reviewed on 10/28/14 at 10:15 a.m. The diagnoses for Resident #82 included, but were not limited to, diabetes mellitus, hypertension, and depression. During an interview with Resident #82, on 10/23/14 at 10:30 a.m., Resident #82 was observed in a hospital gown and Resident #82 indicated that was her clothing preference.	F 279	**F 279** **1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice** · Resident #82 care plan was reviewed and revised to address the preference of wearing a gown **2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken** ·Any residents in the facility who prefer to wear a gown have the potential to be affected. ·The Interdisciplinary team will audit/review all current residents who prefer to wear a hospital gown instead of clothing and develop and/or update care plan accordingly	11/29/2014

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	During the following observations, Resident #82 was observed in a hospital gown: 10/27/14 at 12:48 p.m., 10/27/14 at 2:15 p.m., 10/28/14 at 3:05 p.m., 10/29/14 at 12:55 p.m. A care plan for Resident #82's preference to be dressed in a hospital gown was not located in the Resident's clinical record. During an interview with the Director of Nursing Services (DNS), on 10/30/14 at 10:09 a.m., she indicated care plans were developed to guide staff members on how to care for a resident and if a resident preferred to be in a hospital gown, then there needed to be a care plan for that preference. The DNS indicated she was unable to locate a care plan for Resident #82's gown preference and she will develop a care plan for this clothing preference. 3.1-35(a)		·The IDT team will be educated on resident preference, daily customary routines, and care planning by the DNS or designee on or before 11/29/14 **3: Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.** · Activity Director/ Designee will complete preference for daily customary routines form for each new admission quarterly and annually for resident preferences and report findings to appropriate discipline for care planning ·The IDT team will be educated on resident preference, daily customary routines, and care planning by the DNS or designee on or before 11/29/14 ·IDTwill review and updates all resident care plans for accuracy related to clothingpreference upon admission, quarterly, and annually per MDS schedule. IDT will ensure all care plans are specificand interventions are accurately written. **4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place** ·Acare plan CQI audit tool will be completed for six months with audits beingcompleted once weekly for one month, bi-weekly for 2 months, and then monthlyfor 3 months by a nurse manager or	

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			designee ·TheCare plan CQI audit tool will be reviewed monthly by the CQI Committee for sixmonths after which the CQI team will re-evaluate the continued need for theaudit. If a 95% threshold is not achieved an action plan will be developed. ·Deficiencyin this practice will result in disciplinary action up to and includingtermination of the responsible employee. ·Dateof Compliance 11/29/2014	
F 280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to revise a dialysis care plan, and to ensure a resident's wound care plan was updated for 2 of 23	F 280	**F 280** **1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice**	11/29/2014

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	residents reviewed for care plans. (Residents #16 and #36) Findings include: 1. The clinical record for Resident #36 was reviewed on 10/28/14 at 10:15 a.m. The diagnoses for Resident #36 included, but were not limited to, mental retardation, seizure disorder, diastolic heart failure, and schizoaffective disorder. A Progress Note, dated 10/9/14 at 1:29 p.m., indicated Resident #36's right upper thigh fistula was assessed. A Progress Note, dated 10/13/14 at 3:02 p.m., indicated Resident #36's left upper thigh fistula was assessed. A Progress Note, dated 10/14/14 at 2:10 p.m., indicated Resident #36's left thigh fistula was assessed. A Progress Note, dated 10/15/14 at 2:56 a.m., indicated Resident #36's left upper thigh fistula was assessed. A Dialysis Care Plan, dated 7/14/11 and remained current at time of review, indicated Resident #36 had a right lower extremity access site. The care plan also indicated an intervention of assessing the		·Resident #16 care plan was reviewed and revised to address current dialysis access site ·Resident # 36 care plan was reviewed and revised to address skin alterations and updated interventions **2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken** ·Any residents on dialysis have the potential to be affected by the alleged deficient practice ·Any residents with skin alterations have the potential to be affected by the alleged deficient practice ·The Interdisciplinary team will complete an audit on all current residents who receive dialysis to identify accurate dialysis access site and update care plans accordingly. ·The Interdisciplinary team will complete an audit of all current residents with skin alterations to ensure the care plans are updated appropriately with the current interventions. ·The IDT team will be in-serviced by the DNS or designee on care plans, care planning of dialysis access sites and care planning of wound interventions on or before 11/29/14 **3: Whatmeasures will be put into place or what systemic changes will**	

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	dialysis shunt on the right upper thigh each shift. Resident #36's left lower extremity fistula was not listed as one of Resident #36's dialysis access sites on the dialysis care plan. During an interview with the Director of Nursing Services, on 10/30/14 at 11:49 a.m., she indicated she did not see the left lower extremity listed on the dialysis care plan for Resident #36 and she will update the care plan to reflect all dialysis access sites for Resident #36. 2. Resident #16's record was reviewed on 10/22/14 at 1:22 p.m. The resident's diagnoses included, but were not limited to, anemia, GERD (gastro esophageal reflux disease), parkinson's, CVA (cerebrovascular accident), CHF (congestive heart failure), DM (diabetes mellitus), COPD (chronic obstructive pulmonary disorder), impaired renal function. A Physician's order, dated 10/28/14, indicated Resident #16 had a wound treatment for left posterior thigh wounds. A 9/25/14 initial non-pressure wound skin assessment indicated Resident #16 had 2 blisters on her left posterior thigh area. One of the blisters was in the lower area on the back of the left thigh and one was towards the upper area of the back		**be made to ensurethat the deficient practice does not recur.** ·MDS coordinator will report daily in Interdisciplinary team meeting which residents are due for annual, quarterly or change in condition care plan review. ·The IDT team will review the residents care plans upon admission, with significant change, quarterly and annually to ensure dialysis access sites are identified and care planned appropriately and all wound interventions are care planned appropriately. ·DNS/ designee will review careplans related to change in condition to ensure careplans are up to date for any changes in wounds and or dialysis sites. **4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place** ·Adialysis and skin management CQI audit tools will be completed for six monthswith audits being completed once weekly for one month, bi-weekly for 2 months,and then monthly for 3 months by a nurse manager or designee ·Thedialysis and skin management CQI audit tool will be reviewed monthly by the CQICommittee for six months after which the CQI team will re-evaluate thecontinued need for the audit. If a 95% threshold is	

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	left thigh. A 9/25/14 physician's order indicated for nursing staff to "...Cleanse open blisters to L (left) thigh..." and perform other treatment measures on the wound. On 10/29/14 at 10:07 a.m., during an interview, the Wound Nurse indicated Resident #16's left posterior thigh blisters were observed initially on 9/25/14, the physician was notified and new treatment orders received for the wound, and the wound was assessed weekly thereafter. She indicated the blisters became "open" and the wounds "sort of merged together" between 9/25/14 and 10/14/14. She indicated a wound Nurse Practitioner was consulted on the wounds and saw the wounds weekly beginning 10/7/14. A wound assesment, dated 10/7/14, indicated the wound to Resident #16's left posterior leg was an "...Eschar covered Skin Tear..." which was not healed. The note indicated the measurements of the wound to be 6.2cm (centimeters) length x 9.1 cm width. On 10/29/14 at 10:25 a.m., the Wound Nurse indicated she did not update Resident #16's wound care plan with new interventions to address the left posterior thigh wound change in condition. She		not achieved an action planwill be developed. ·Deficiencyin this practice will result in disciplinary action up to and including terminationof the responsible employee. ·Dateof Compliance 11/29/2014	

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	155029		10/30/2014

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	indicated she should have updated the care plan with a new interventions for nursing staff to follow regarding the left posterior thigh wounds. On 10/29/14 at 11:17 a.m., during an interview, the DNS indicated resident care plans should be updated according to facility policy. A facility policy, dated 4/2014 and titled "IDT Care Plan Review" indicated "...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition..." 3.1-35(d)(2)(B)			
F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to encourage fluids to a resident, as care planned, for 1 of 23 residents reviewed for following care plans. (Resident #155) The facility also failed to follow Physician's Orders for obtaining routine labs for 1 of 6 residents reviewed for following Physician's Orders. (Resident	F 282	**F282** **1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice** ·In regards to Resident # 155 all dietary staff were in-serviced on the facilities process on providing thickened liquids on meal trays. Resident #155 has received fluids	11/29/2014

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	#48) Findings include: 1. The clinical record for Resident #155 was reviewed on 10/24/14 at 10:00 a.m. The diagnoses for Resident #155 included, but were not limited to, history of hyponatremia and dysphagia. The 8/13/14 Dehydration/Fluid Maintenance care plan for Resident #155 indicated she was at risk for fluid imbalance, with an intervention to encourage fluids. An interview was conducted with Resident #155 on 10/24/14 at 10:10 a.m., regarding whether she received the fluids she wanted in between meals. She indicated she did not receive the fluids she wanted with meals and stated, "They forget my drink a lot." A test tray from the dietary department of the facility was received on 10/27/14, at 12:25 p.m. There were no drinks on the tray. An interview was conducted with the Administrator on 10/27/14, at 12:45 p.m. He indicated, "I think they (dietary) just missed the drink. When we pass trays in the halls, we pass the drinks and trays		as care planned with each meal. ·In regards to Resident # 48 all nurses were in-serviced on scheduling LABs. Resident # 48's LABs have been scheduled and will be completed as physician ordered **2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken** ·All residents with physician orders for thickened liquid have the potential to be affected by the alleged deficient practice ·All residents with physician orders for routine LABs have the potential to be affected by the alleged deficient practice ·Dietary staff was in-serviced by Dietary Manager on November 13th 2014, regarding the necessary fluids to provide on each meal tray for residents care planned for thickened liquids. ·Licensed nursing staff was in-serviced by Clinical Education Coordinator on November 11th, 2014, regarding scheduling LABs per physician's orders. ·Dietary manager or designee will audit residents who are care planned to receive thickened to ensure the meal ticket is accurate and that the fluids are provided on meal trays with each meal per the resident's plan of care. ·ADNS or designee will audit all routine labs scheduled for the last 30 days to ensure they were	

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	separately. Usually, the drinks come first." An interview was conducted with Resident #155 on 10/27/14, at 12:38 p.m. She was sitting in her room, with her lunch meal tray on her bedside table. She stated, "I didn't get my drinks with my meal. I'm on nectar thick liquids." Family Member #5 was present at this time. Family Member #5 stated, "I had to go ask for the drinks after her tray came." An interview was conducted with the DSM (Dietary Services Manager) on 10/27/14 at 1:00 p.m. He indicated, "Our process is when someone is on nectar thick liquids, to put the drinks on the tray. We could have missed it." A copy of Resident #155's 10/27/14 Lunch ticket was provided on 10/27/14 at 1:00 p.m. It indicated, "Nectar Thick." 2. The clinical record for Resident #48 was reviewed on 10/29/14 at 12:15 p.m. The diagnoses for Resident #48 included, but were not limited to, benign brain tumors, severe dementia with depression, and toxic metabolic encephalopathy. A review of the October Physician's Orders indicated an order to obtain a CMP (comprehensive metabolic panel-blood test) lab every 6 months in		drawn appropriately. **3: Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.** ·Dietary staff was in-serviced by Dietary Manager on November 13th 2014, regarding the necessary fluids to provide on each meal tray for residents care planned for thickened liquids. ·Licensed nursing staff was in-serviced by Clinical Education Coordinator on November 11th, 2014, regarding scheduling LABs per physician's orders. ·When a lab order is written the staff nurse will notify the lab of the needed order and ensure it is scheduled appropriately. The following business day the nurse management team will review all lab orders and verify that they were scheduled with the lab appropriately. The labs will be logged in the lab tracking binder and tracked until the lab is completed. ·Dietary manager or designee will check room trays daily to ensure thickened fluids are provided on residents trays as care planned. ·The nurse management team will review all lab orders written Monday through Friday to ensure they are scheduled with the lab appropriately. The house supervisor or designee will check all lab orders on Saturday and Sunday to ensure they were	

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	April and October. The order was initiated on 7/17/13. A CMP was obtained on 10/17/13. No other CMP labs were located in the clinical record. A copy of the CMP lab for April 2014 was requested from the Director of Nursing Services (DNS) on 10/29/14 at 2:55 p.m. During an interview with the DNS, on 10/30/14 at 10:09 a.m., she indicated the lab company indicated to her that the CMP lab was listed as a one time order instead of every 6 months as the Physician ordered. The DNS further indicated the CMP lab was not obtained in April due to this miscommunication. 3.1-35(g)(2)		scheduled appropriately. **4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place** ·To ensure compliance the Dietary Manager/Designee will complete the Room Trays CQI 2 times weekly X4 weeks, bi weekly X 2 months, monthly x 4 months and quarterly thereafter. ·To ensure compliance the DNS/Designee will complete the LAB/Diagnostics tracking CQI weekly X4 weeks, bi weekly X 2 months, monthly x 4 months and quarterly thereafter. ·The result of these audits will be reviewed monthly by the CQI committee overseen by the ED. ·If threshold of 100% is not achieved, a revised action plan will be developed to assure compliance. ·date of compliance November 29, 2014.	
F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.			

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	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure a resident did not receive a flu shot, 18 days after having just received one, for 1 of 6 residents reviewed for unnecessary medications. (Resident #172) Findings include: The clinical record for Resident #172 was reviewed on 10/29/14, at 10:30 a.m. She was admitted to the facility on 10/15/14 from the hospital. The 10/9/14 hospital records for Resident #172, included in Resident #172's clinical record, indicated she received an influenza vaccine on 10/4/14. The 10/22/14 Physician Telephone Order for Resident #172 indicated, "Flu vaccine x 1 IM (intramuscularly) v/s (vital signs) prior to vaccine..."	F 329	**F329** **Facility respectively requesting faceto face IDR for F329 as facility disagrees with scope and severity assigned tothis deficiency.** **1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice** ·In regards to Resident # 172 all nurses were in-serviced on adequate inquiry of residents' history of FLU vaccinations on admission. Resident #172 did not experience any adverse effects. **2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken** ·All new admissions have the potential to be affected by the alleged deficient practice ·Licensed nursing staff was in-serviced by Clinical Education Coordinator on November 11th, 2014, regarding adequate inquiry of residents' history of FLU	11/29/2014

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	The October, 2014 MAR (medication administration record) for Resident #172 indicated she received a flu vaccine in the facility, on 10/22/14. An interview was conducted with the DON (Director of Nursing) on 10/29/14, at 11:56 a.m. She indicated, "We started giving flu vaccines on October 1st. It looks like she (Resident #172) got it on 10/22/14." Regarding whether it was necessary for Resident #172 to receive a flu shot on 10/22/14, she indicated, "It was not necessary for her to receive the flu vaccine on 10/22/14, if she just received it on 10/4/14. I didn't know about the 10/4/14 flu vaccine. If we'd have known, we wouldn't have given it." 3.1-48(a)(1)		vaccinations on admission. ·The IDT team was in-serviced on admission chart reviews and identifying current immunizations and immunization consents on or before 11/29/14 by the DNS or designee. ·DNS/Designee will audit all admissions in the last 30 days to ensure immunizations were administered appropriately. **3: Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.** ·Licensed nursing staff was in-serviced by Clinical Education Coordinator on November 11th, 2014, regarding adequate inquiry of residents' history of FLU vaccinations on admission. ·The IDT team was in-serviced on admission chart reviews and identifying current immunizations and immunization consents on or before 11/29/14 by the DNS or designee. ·Upon admission the resident or POA will be educated on and complete a flu and pneumonia consent form. The Interdisciplinary team will review all new admissions medical records to determine if the resident has already received a flu vaccine and document accordingly. The IDT team will review the resident's flu and pneumonia consent and admission immunization documentation to ensure the	

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			resident does not receive an immunization unnecessarily. ·The DNS or designee will review each new admission chart and immunization consents to ensure the resident is immunized appropriately. **4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place** ·Aflu vaccine CQI audit tool will be completed for six months with audits beingcompleted once weekly for one month, bi-weekly for 2 months, and then monthlyfor 4 months by a nurse manager or designee ·Theflu vaccine CQI audit tool will be reviewed monthly by the CQI Committee forsix months after which the CQI team will re-evaluate the continued need for theaudit. If a 95% threshold is not achieved an action plan will be developed. ·Deficiencyin this practice will result in disciplinary action up to and includingtermination of the responsible employee. ·Dateof Compliance 11/29/2014	
F 372 SS=C Bldg. 00	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure a dumpster properly contained garbage with closed	F 372	**F-372- Disposegarbage and refuse properly Facility respectively requesting faceto face IDR for F372 as facility**	11/29/2014

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	and appropriately fitting lids. This had the potential to affect 95 residents residing in the facility. Findings include: During a random observation with the Dietary Manager, on 10/22/14 at 2:20 p.m., the garbage dumpster was observed with an opened lid. During an interview with the Dietary Manager, on 10/22/14 at 2:21 p.m., he indicated the dumpster lids needed to be closed at all times. During the following observations, the dumpster was observed with an opened lid: 10/28/14 at 1:15 p.m., 10/28/14 at 3:44 p.m., 10/29/14 at 10:05 a.m., 10/29/14 at 2:55 p.m., 10/30/14 at 9:30 a.m. During an interview with the Administrator, on 10/30/14 at 10:42 a.m., he indicated he emailed the waste service company last week on Thursday (10/23/14) for a new dumpster with side doors, so that it was easier for staff to keep the dumpster closed. The Administrator also indicated the lids needed to be closed to help keep out		**disagrees with scope and severity assigned tothis deficiency. 1. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;** ·Noresidents were identified as being affected by the alleged deficient practice. Anew trash receptacle was ordered on 10/28/2014 and placed on 10/31/2014 byRepublic Trash Services. New trash can has the top door locked so that itcannot be opened and now has side access ports for staff to use to dispose ofgarbage. 2 **howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; ;** ·Allresidents residing in the facility have the potential to be affected by thealleged deficient practice. ·Anew trash receptacle was ordered on 10/28/2014 and placed on 10/31/2014 byRepublic Trash Services. New trash can has the top door locked so that itcannot be opened and now has side access ports for staff to use to dispose ofgarbage. ·TheED/designee in serviced the maintenance supervisor on ensuring the facilitytrash containers have an appropriate closing lid on or before 11/29/14 ·Facilitystaff were inserviced on	

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	pests/rodents. 3.1-21(i)(5)		ensuring the facility trash bins have the lids closedat all times. This education will beprovided by the CEC or designee on or before 11/29/14 **3. whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;** ·TheED/designee in serviced the maintenance supervisor on ensuring the facilitytrash containers have an appropriate closing lid on or before 11/29/14 ·Facilitystaff were inserviced on ensuring the facility trash bins have the lids closedat all times. This education will beprovided by the CEC or designee on or before 11/29/14 ·Themaintenance supervisor or house supervisor will check the trash bins daily toensure the lids are closed and have an appropriately fitting lid. **4. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·ExecutiveDirector or Designee will monitor the trash bins 3x daily 5 days/week for 4weeks then 5x/week for 3 months, then weekly x2 months to ensure compliance. ·Data will be given to QAcommittee monthly to ensure compliance for 6 months after which the CQI team will re-evaluate the continuedneed for	

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			the audit. If a 100% threshold is not achieved an action plan will bedeveloped. ·Deficiencyin this practice will result in disciplinary action up to and includingtermination of the responsible employee. ·Date of Compliance 11/29/2014.	
F 412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to ensure there was adequate communication/a follow up visit with a dental service for 1 of 3 residents reviewed for dental services. (Resident #74) Findings include: The clinical record for Resident #74 was reviewed on 10/27/14 at 2:25 p.m. The diagnoses for Resident #74 included, but were not limited to, traumatic brain injury, post traumatic seizures, schizophrenia and kidney disease.	F 412	**F-412-Emergency Dental services** **1.what corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice**; Resident 74 has been placed onlist to be seen by dentist at their next facility visit in November. **2. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken;** ·Allresidents have the potential to be affected by the alleged	11/29/2014

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	An Oral Assessment, dated 3/17/14, indicated Resident #74 was seen by a dentist. No follow up/next appointment timeframe was indicated on the Assessment. A Progress Note, dated 3/18/14 at 3:22 p.m. indicated, "Resident was seen by [Name of Dental Group] on 3/17/14 for an oral assessment. Resident has natural teeth without dentures." No follow up/next appointment timeframe was indicated in the progress note. During an interview with the Social Services Director (SSD), on 10/27/14 at 2:35 p.m., the SSD indicated she was unable to determine when Resident #74 needed to be seen next by the dentist, so she will follow up with the Dental Group. On 10/28/14, at 10:20 a.m., the SSD indicated she received a voicemail from the Dental Group. The SSD further indicated the voicemail indicated the Dental Group was waiting on a consent from Resident #74's family for dental treatment and Resident #74 was supposed to be seen 6 months after his 3/17/14 visit. The SSD also indicated the facility does do dental consents upon a resident's admission, but she had not had a chance to look to see if Resident #74 had one on		deficient practice. ·SocialServices Director will audit the past 12 months of dental exams from DentalGroup and ensure the residents have received the appropriate dental treatmentas requested by resident or POA ·TheSocial services dept will be educated on dental consents, dental groupevaluations, and procedure for ensuring follow up dental appts are scheduledand consents obtained by the social service director or designee on or before11/29/14 · Social Service Director and Clinical ResourceCoordinator of Dental Group will collaborate to capture resident's enrolled indental program. This collative tool willbe completed on excel spreadsheet to capture those residents continuing withservices, those residents declining services and those residents in need ofconsent by resident/family, and those in need of services. **3. whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;** ·SSDor designee will collaborate with clinical resources coordinator of dentalgroup to ensure that resident's need of consent/services is met. SSD or designee will contact clinicalresource coordinator of dental group monthly prior to facility scheduled visitto	

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	file. At 11:48 a.m., on 10/28/14, the SSD indicated the Dental Group had been trying to contact Resident #74's family since January, but the facility was unaware of this. The SSD further indicated Resident #74 was not seen in September because the Dental Group did not have consent from the family. The SSD indicated if the facility was notified about the lack of consent for dental services for Resident #74, the facility would've been able to assist the Dental Group with obtaining a dental consent. The SSD also indicated the facility changed dental companies/services in 2012 so she was unsure if Resident #74's dental consent was still valid. On 10/28/14, at 12:46 p.m., the SSD indicated she was able to obtain a verbal consent for dental services from Resident #74's family and Resident #74 was put on the dental appointment list for November. The SSD also indicated she was unable to locate Resident #74's previous dental consent. A Missing Teeth/Poor Oral Hygiene Care Plan, dated 10/11/11, indicated the intervention: dental consult as indicated. 3.1-24(a)(1)		communicate those in need of consent/services. Clinical resources Coordinator at that time will request any face sheets/consentsof resident's needed. SSD or designeewill obtain these items and fax to dental group. ·Anintra-facility checklist tool will be developed to track and monitor resident'sconsents and appointments to ensure that residents are given the opportunity toreceive dental services. This tool will be updated twice monthly before andafter facility scheduled visit. A dentalgroup case management will be updated monthly by dental group and given tosocial services. ED/ designee willmonitor checklist monthly for compliance. ·TheSocial services dept will be educated on dental consents, dental groupevaluations, and procedure for ensuring follow up dental appts are scheduledand consents obtained by the social service director or designee on or before11/29/14 **4. howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·Social service director or Designeewill complete the dental services CQI weekly X4 weeks, bi weekly X 2 months,monthly x 4 months and quarterly thereafter.	

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	155029		10/30/2014

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			·The dental services CQI audit tool will bereviewed monthly by the CQI Committee for six months after which the CQI teamwill re-evaluate the continued need for the audit. If a 100% threshold is notachieved an action plan will be developed. ·Deficiency in this practice will result indisciplinary action up to and including termination of the responsibleemployee. ·Date of Compliance 11/29/2014.	
F 441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program 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			

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	a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's catheter tubing remained off the floor during random observations. (Resident #132) The facility also failed to maintain a infection control monitoring/surveillance log for 2 months. This had the potential to affect 95 residents residing in the facility. Findings include: 1. On 10/23/14, at 1:59 p.m., Resident #132's catheter tubing was noted observed on the floor, next to Resident #132's bed. At 1:12 p.m., on 10/24/14, Resident #132's catheter tubing and catheter bag were observed laying on the floor, next to Resident #132's bed. On 10/29/14, at 12:58 p.m., Resident	F 441	**F441** **Facility respectively requesting faceto face IDR for F441 as facility disagrees with scope and severity assigned tothis deficiency.** **1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice** ·In regards to Resident # 132 all nursing staff was in-serviced on infection control monitoring to ensure catheter tubing remained off of the floor. Resident 132 catheter tubing was positioned so that it is not touching the floor. Resident # 132 was provided a receptacle to encourage resident from lying catheter on the floor. Resident # 132's plan of care was updated. ·Facilities infection control monitoring/surveillance log has been updated and maintained. **2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be**	11/29/2014

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	#132's catheter tubing and catheter bag were observed laying on the floor, next Resident #132's bed. During an interview with the Infection Control RN/Clinical Educator Clinician (CEC), on 10/30/14 at 12:15 p.m., the CEC indicated it was against facility practice for catheter tubing to be on the floor because it was a possible infection control issue. On 10/30/14, at 1:37 p.m., the Director of Nursing Services indicated the facility did not have a specific policy related to catheter tubing being kept off the floor. The DNS further indicated it was facility practice to keep catheter tubing off the floor because it was a potential infection control issue. 2. During an interview with the Infection Control RN/Clinical Educator Clinician (CEC), on 10/30/14 at 12:10 p.m., the CEC indicated the Infection Control Tracking/Surveillance Log was incomplete because February and March 2014 were not reviewed/analyzed for infections/infection control issues. The CEC further indicated she was unsure why those months were not analyzed because she did not work at the facility at that time. The CEC also indicated the facility's corporate office came up with		**taken** ·All residents with catheters have the potential to be affected by the alleged deficient practice ·All residents who reside in the facility have the potential to be affect by the alleged deficient practice of failing to maintain a monthly infection control surveillance log. ·The facility nursing staff will be educated on infection control techniques pertaining to keeping catheter tubing off of the floor by the CEC or designee on or before 11/29/14 ·The DNS or designee will re-educate the CEC on appropriate infection control surveillance monitoring on or before 11/29/2014 ·An audit will be performed on all residents with a catheter to ensure the catheter tubing is not touching the ground on or before 11/29/14 ·The DNS audited the infection control surveillance log to ensure it was accurate and up to date on or before 11/29/14. **3: Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.** ·All nursing staff was in-serviced by Clinical Education Coordinator on November 11th, 2014, regarding infection control monitoring to ensure catheter tubing remains off of the floor. ·The DNS or designee will	

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	an action plan for the missing months and the CEC indicated she was supposed to analyze February and March 2014 data/infections/infection control issues when she had time. The number of residents that had a diagnosis of C. diff (Clostridium difficile), MRSA (Methicillin-resistant Staphylococcus aureus), or VRE (vancomycin-resistant enterococcus) was requested at this time. On 10/30/14, at 1:20 p.m., the CEC indicated 1 resident had a facility acquired diagnosis of C. diff. and that was the only information she was able to obtain regarding the above diagnosis, at that time. A policy titled, Surveillance System, dated 12/11, was received from the Director of Nursing Services on 10/30/14 at 1:37 p.m. The policy indicated, "...The facility shall have [sic] surveillance system that investigates, controls, and prevents infections....**Monitor:** Provide ongoing tracking to rule out an infection, the development of a new/recurrent infections, and/or spread of infections...." 3.1-18(b)(1)(A) 3.1-18(b)(3) 3.1-18(b)(2)		re-educate the CEC on appropriate infection control surveillance monitoring on or before 11/29/2014 ·DNS/Designee will conduct daily rounds each shift on all residents with catheters to ensure catheter tubing remains off of the floor. ·The DNS/Designee will evaluate the infection control surveillance log weekly to ensure appropriate monitoring. ·Clinical Education Coordinator will maintain facilities infection control monitoring/surveillance log per policy. ·Nursing staff will ensure that residents with Foley catheters have the tubing maintained off of the floor by conducting rounds each shift. **4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place** ·To ensure compliance the DNS/Designee will complete the Catheters CQI weekly X4 weeks, bi weekly X 2 months, monthly x 4 months and quarterly thereafter. ·To ensure compliance the Clinical Education Coordinator /Designee will complete the Infection Control CQI weekly X4 weeks, bi weekly X 2 months, monthly x 4 months and quarterly thereafter. ·The catheter and infection control CQI audittools will be	

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			reviewed monthly by the CQI Committee for six months after whichthe CQI team will re-evaluate the continued need for the audit. If a 100%threshold is not achieved an action plan will be developed. ·Deficiency in this practice will result indisciplinary action up to and including termination of the responsibleemployee. ·Date of Compliance 11/29/2014.	