STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 6, 7, 8, 9, and 10, 2015 Facility number: 000305 Provider number: 155625 AIM number: 100287200 Census bed type: SNF/NF: 65 Total: 65 Census payor type: Medicare: 4 Medicaid: 48 Other: 13 Total: 65 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	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 requests a desk review in lieu of a Post Survey Review on or after May 4, 2015	
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			

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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	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 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 observation, interview and record review, the facility failed to notify the resident's physician and responsible party when the resident did not receive the prescribed medication for pain following a narcotics count discrepancy for one of four narcotics counts completed. This deficiency had the potential to affect one of one resident	F 157	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident#1 was not harmed byalleged deficient practice. ·Allnurses in-serviced on notifying MD/responsible party and medication error policy/procedure by Director of Nursing and/or designee on 4/29/15.	05/04/2015

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	reviewed for notification of change. (Resident #1) Findings include: A narcotics count of the medication cart for the 200 hall was conducted with RN (Registered Nurse) #6 on 04/08/2015 at 3:53 P.M. Resident #1's medication card containing Tramadol had seven pills left in the bubbled punch-out card. The prescription label on the top of the card indicated the tablets were 50 mg (milligram) tablets and the resident was to receive two tablets (100 mg) by mouth three times a day. RN #6 indicated she had given the resident one tablet during the two o'clock medication pass. Review of the electronic Medication Administration Record with RN #6 at that time, indicated she had given the medication at 2:30 P.M. RN #6 verbally acknowledged she should have given the resident two tablets. The nurse further indicated the computer does not indicate how many tablets are given. On 04/08/2015 at 4:05 P.M., RN #6 provided a copy of Resident #1's Tramadol medication documentation record from the Narcotics Book for the 200 hall. The record indicated two tablets had been given on 04/08/2015 at 8:00 A.M. and the quantity remaining		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·Residents who reside inthis facility have the potential to be affected by the alleged deficient practice. ·All nurses in-serviced on notifying MD/responsible party and medication error policy/procedure by Director of Nursing and/or designee by 4/29/15. ·Director of Nursing completed narcotic count audit on 4/29/15 with no concerns noted. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·All nurses in-serviced on notifying MD/responsible party and medication error policy/procedure by Director of Nursing and/or designee by 4/29/15. ·Director of Nursing and/or designee will complete an audit tool for narcotic counts on all medication carts daily; Medication error policy/procedure will be followed for any discrepancies including MD and responsible party notification **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	was eight. On 04/08/2015 at 4:10 P.M., RN #6 provided a copy of Resident #1's Tramadol medication card containing seven tablets. Review of the Medications Administration History report, provided by the DON (Director of Nursing) on 04/10/2015 at 3:32 P.M., indicated Resident #1 had 100 mg of Tramadol due at 2:00 P.M. on 04/08/2015. The "Med Pass General Guidelines" policy and procedure was provided by the Clinical Education Coordinator on 04/08/2015 at 4:31 P.M. and was verified as current. Item #14.0 indicated medication errors and drug reactions must be immediately reported to the resident's physician, the DON, the administrator, and the resident's responsible party. An entry must be made in the resident's clinical record and an incident report, as per the facility's policy and procedure, completed. On 04/10/2015 at 3:14 P.M., during an interview with the DON, she indicated she was not aware of any recent medication errors. No incident report was noted in the computer chart or in Resident #1's paper chart.		**into place?** ·A daily audit tool for narcotic counts will be completed by Director o fNursing and/or designee ·A Medication Error CQI tool will be utilized by Director of Nursing and/or designee weekly x 4weeks, monthly x 6 months and quarterly thereafter ·Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.	

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	On 04/10/2015 at 3:25 P.M., during an interview with the DON, she again indicated she was not aware of any medication errors. After she was made aware of the narcotics count completed on 04/08/2015, she indicated she would assess the resident and fill out the appropriate paperwork. The doctor's order, provided by the DON on 04/10/2015 at 3:32 P.M., indicated, "tramadol tablet; 50 mg; Amount to Administer: 100 mg; Oral". On 04/10/2015 at 3:51 P.M. the DON provided a Medication/Treatment Error Report dated 04/10/2015. The report indicated the Physician was notified on 04/10/2015 at 3:30 P.M. and the family was notified on 04/10/2015 at 3:34 P.M. 3.1-5(a)			
F 250 SS=E Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.			

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	Based on observation, interview and record review, the facility failed to maintain comfortable sound levels, related to Resident #3 yelling out day and night. This deficient practice resulted in difficulty for residents to concentrate, visit with family and sleep. This had the potential to affect 49 residents residing in halls 100, 200 and 400 of the facility. Findings include: During an observation on 04/06/2015 at 7:45 A.M., upon entering the facility loud yelling was echoing from the end of the 200 hallway and could be heard throughout the 100 hall, the main corridor, and the main dining room. The yelling continued intermittently throughout the day. On 04/07/2015, at 9:55 A.M., Resident #3 was observed sitting in front of the bird cage, yelling for help. On 04/10/2015, from 9:42 A.M. through 12:45 P.M., loud intermittent yelling was echoing down the hallways. Staff had made several attempts to redirect Resident #3 without success. During interview on 04/06/2015 at 9:44 A.M., Resident #82 indicated the noise level was extremely loud. The resident	F 250	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·All staff in-serviced on behavior interventions and noise level on 4/29/15. ·Resident #3 was seen by psych on 4/21/15 with changes made to resident medications ·Resident #3 had decrease in frequency of scheduled breathing treatments per physician order on 4/28/15 due to possible contributing factor to resident anxiety ·New interventions were added to Resident #3 care plan for yelling on 4/27/15 after meeting with POA ·Resident #3 medications were readjusted per psych recommendation on 4/28/15 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·Residents who reside on hallways 100, 200 and 400 have the potential to be affected by the alleged deficient practice. ·All staff in-serviced on behavior interventions and noise level by Director of Nursing and/or designee on 4/29/15 ·Care Plan meeting held with Resident #3 POA on 4/27/15 with Director of Nursing, Executive Director and Social Service Director to discuss current	05/04/2015

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	indicated, "The other resident screams and screams. Staff cannot do anything to stop the yelling". Resident #82 indicated staff members were aware of the noise disturbing other residents. Resident #82 further indicated the yelling had interrupted conversations with friends and family. During an interview on 04/06/2015 at 11:15 A.M., Resident #45 indicated the noise coming from the hallway was extremely loud. The resident indicated being able to hear someone yelling all day and night. During an interview on 04/06/2015 at 11:23 A.M., Resident #42 indicated the yelling from across the hall was loud and continued night and day. The resident indicated some nights being awakened by the noise level. The resident further indicated some nights the staff cannot stop the resident from yelling. During an interview on 04/10/2015 at 12:55 P.M., the Social Service Director (SSD) indicated the facility had one resident whom yells loudly on and off throughout the day. The SSD indicated multiple interventions were attempted by staff, and as a last resort, a family member of the resident was called to help comfort the resident. The SSD indicated,		behaviors, interventions and medications ·Family members interviewed by Customer Care Representatives regarding noise level by 5/1/15; any concerns will be placed on a grievance form and the grievance protocol will be followed ·Residents interviewed by Customer Care Representatives regarding noise level by 5/1/15; any concerns will be placed on a grievance form and the grievance protocol will be followed **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·All staff in-serviced on behavior interventions and noise level by Director of Nursing and/or designee on 4/29/15. ·Care plan meeting held with Resident #3 POA on 4/27/15 with Director of Nursing, Executive Director and Social Service Director to discuss current behaviors, interventions and medications ·Director of Nursing and/or designee will utilize a daily audit tool to assess the effectiveness of Resident #3 behavior interventions and frequency of behaviors ·Family members interviewed by Customer Care Representatives regarding noise level by 5/1/15 ·Residents interviewed by	

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	in the past month, the physician had attempted to make medication changes for the resident. During an interview on 04/10/2015 at 1:13 P.M., QMA (Qualified Medication Aide) #2 indicated the staff made several attempts to take care of the resident's needs to prevent the resident from yelling. The QMA indicated the noise had upset the resident's roommate on several occasions. Record review for Resident #3, on 04/10/2015 at 3:35 P.M., indicated the following: The most recent Minimum Data Set (MDS) assessment, dated 12/31/2014, indicated a Brief Interview for Mental Status (BIMS) score of 03 for Resident #3. This score indicated the resident was cognitively impaired. The verbal behavioral symptoms directed toward others occurred one to three days out of a seven day look back. "Signs and symptoms of Delirium" assessment, indicated no behavior present for inattention, disorganized thinking or altered level of consciousness. The Behavior Administration History, dated 3/11/2015 through 4/10/2015, indicated Resident #3 had episodes of		Customer Care Representatives regarding noise level by 5/1/15 ·Any uncomfortable sound level identified by residents or family members will be immediately investigated by the Director of Nursing and/or designee with new interventions put into place based on behavior management plan ·Weekly care plan meetings scheduled with Resident #3 POA ·Staff will interview residents quarterly regarding noise level using the CQI questionnaire; any concerns will be investigated by the Director of Nursing and/or designee and corrective actions will be taken accordingly **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·A Behavior Management CQI tool will be utilized by Director of Nursing and/or designee weekly x4 weeks, monthly x 6 months and quarterly thereafter ·An Accommodation of Needs CQI tool will be utilized by Director of Nursing and/or designee weekly x4 weeks, monthly x 6 months and quarterly thereafter ·Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.	

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	yelling out while in the resident's room, the hallway and in the shower room. The behavior flow chart indicated the resident had a frequency of episodes twice a day and the resident's behavior started on 11/12/2013. 3.1-34(a)			
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 interview and record review, the facility failed to ensure the plan of care was followed as written, related to restorative range of motion for 2 of 6 residents reviewed for activities of daily living of the 19 residents who met the criteria for activities of daily living. (Resident # 4 & #11) Findings include: 1. Record review for Resident #4, on 04/09/2015 at 1:20 P.M., indicated the following:	F 282	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident#4 and Resident #11 were not harmed by alleged deficient practice. ·Restorative aides in-serviced on following restorative care plans on 4/29/15. ·Resident #4 and Resident #11 are receiving Active Range of Motion 6 days per week per care plan **How will you identify other residents having the potential**	05/04/2015

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	Resident #4's care plan for Activities of Daily Living (ADLs), dated 01/28/2015, indicated the resident had a self care deficit related to severe scoliosis of the spine and paraplegia. The resident required assistance with ADLs. The approach was to provide a restorative nursing program as indicated for maintenance of functional status. Resident #4 had a care plan for Active Range of Motion (AROM), dated 01/28/2015. The goal was to perform thirty repetitions of AROM to bilateral lower extremities, two sets of ten repetitions to bilateral upper extremities, and gentle trunk and neck stretching performed 6 days per week. The "Restorative Flowsheet " for Resident #4 indicated the resident did not receive AROM on March 1, 2, 3, 7, 8, 11, 14, 15, 20, 21, 22, 27, 28, and 29 of 2015. The resident did not receive AROM on April 3, 4 and 5 of 2015. During an interview, on 04/09/2015 at 1:30 P.M., RN #3 indicated restorative aides do not work on Sundays and residents do not get AROM on Sundays. The restorative therapy for Resident #4 was only scheduled for six days a week. RN #3 acknowledged several missing		**to be affected by the same deficient practice and what corrective action will be taken.** ·Residents receiving restorative services have the potential to be affected by the alleged deficient practice. ·Restorative aides in-serviced on following restorative care plans by Director of Nursing and/or designee on 4/29/15. ·Audit was conducted by MDS Coordinator on 4/30/15 for all residents who receive restorative services to ensure all residents care plans are being followed **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Restorative aides in-serviced on following restorative care plans by Director of Nursing and/or designee on 4/29/15. ·Audit was conducted for all residents who receive restorative services to ensure all residents care plans are being followed ·Daily audit tool will be completed by Director of Nursing and/or designee to ensure restorative flow sheets are completed daily and restorative services are being provided 6 days per week **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	dates for AROM therapy besides the expected missing dates on Sundays and indicated she was not aware of the reason for the missed therapy days. 2. Record review for Resident #11, on 04/10/2015 at 4:10 P.M., indicated the following: Resident #11's care plan for ADLs, dated 01/14/2015, indicated the resident requires assistance at times with ADLs. The approach was to treat medical symptoms as ordered and necessary such as pain, weakness, and behaviors. Resident #11 had a care plan for AROM, dated 01/14/2015, to prevent decline of strength and motion. The goal was to perform twenty repetitions of AROM to bilateral upper and lower extremities 6 days per week. The "Restorative Flowsheet " for Resident #11 indicated the resident did not receive AROM on January 3, 4, 6, 9, 10, 17, 18, 23, 24, 25, 28, and 31 of 2015. The resident did not receive AROM on February 1, 7, 8, 10, 14, 15, 16, 21, 22, 25, and 28 of 2015. The resident did not receive AROM on March 1, 7, 8, 11, 14, 15, 20, 21, 22, 27, 28, and 29 of 2015.		**into place?** ·Audit tool will be completed by Director of Nursing and/or designee daily to ensure restorative flow sheets are completed daily and restorative services are being provided 6 days per week ·A Restorative Nursing CQI tool will be utilized by Director of Nursing and/or designee weekly x4 weeks, monthly x 6 months and quarterly thereafter ·Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.	

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	3.1-35(g)(2)			
F 311 SS=D Bldg. 00	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services to maintain or improve Activities of Daily Living (ADLs) related to restorative therapy for 2 of 6 residents reviewed, as indicated by the comprehensive assessment for ADLs. (Resident #4 & #11) Findings include: 1. During an observation, on 04/06/2015 at 10:10 A.M., Resident #4 required the assistance of CNA #7 to remove soiled clothing and dress in a clean shirt. Record review for Resident #4, on 04/09/15 at 1:20 P.M., indicated the following:	F 311	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #4 and Resident #11 were not harmed during alleged deficient practice. ·Restorative aides in-serviced on following restorative care plans by Director of Nursing and/or designee on 4/29/15. ·Resident #4 and Resident #11 are receiving Active Range of Motion 6 days per week per care plan **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·Residents receiving restorative services have the potential to be	05/04/2015

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	Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/06/2014, indicated the resident was cognitively intact and required set up only, for dressing. Review of the Significant Change MDS assessment, dated 01/21/2015, indicated the resident was cognitively intact and required extensive assistance for dressing. Resident #4's care plan for Activities of Daily Living (ADLs), dated 01/28/2015, indicated the resident required assistance with ADLs. The approach was to provide a restorative nursing program as indicated for maintenance of functional status. Resident #4's care plan for Active Range of Motion (AROM), dated 01/28/2015, indicated the resident required AROM. The goal was for the resident to receive AROM six days per week. The "Restorative Flowsheet " for Resident #4 indicated the resident did not receive AROM on March 1, 2, 3, 7, 8, 11, 14, 15, 20, 21, 22, 27, 28, and 29 of 2015. The resident did not receive AROM on April 3, 4 and 5 of 2015. During an interview, on 04/09/2015 at		affected by the alleged deficient practice. ·Restorative aides in-serviced on following restorative care plans by Director of Nursing and/or designee on 4/29/15. ·Audit was conducted by MDS Coordinator on 4/30/15 for all residents who receive restorative services to ensure all residents care plans are being followed **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Restorative aides in-serviced on following restorative care plans by Director of Nursing and/or designee on 4/29/15. ·Audit was conducted for all residents who receive restorative services to ensure all residents care plans are being followed ·Daily audit tool will be completed by Director of Nursing and/or designee to ensure restorative flow sheets are completed daily and restorative services are being provided 6 days per week **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Audit tool will be completed by Director of Nursing and/or designee daily to ensure restorative flow sheets are completed daily and restorative	

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	155625		04/10/2015

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ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

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	1:30 P.M., RN #3 acknowledged several missing dates for AROM therapy for Resident #4. The RN indicated she was not aware of the reason for the missed therapy days. 2. Record review for Resident #11, on 04/10/15 at 4:10 P.M., indicated the following: Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/17/2014, indicated the resident was cognitively intact, physically independent with dressing, and required partial physical help with bathing. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/11/2015, indicated the resident was cognitively intact, required limited assistance with dressing and total dependence with bathing. Resident #11's care plan for AROM, dated 01/14/2015, indicated the resident required AROM to prevent decline of strength and motion. The goal was for the resident to receive AROM six days per week. The "Restorative Flowsheet " for Resident #11 indicated the resident did not receive AROM on January 3, 4, 6, 9,		services are being provided 6 days per week ·A Restorative Nursing CQI tool will be utilized by Director of Nursing and/or designee weekly x4 weeks, monthly x 6 months and quarterly thereafter ·Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met.	

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	10, 17, 18, 23, 24, 25, 28, and 31 of 2015. The resident did not receive AROM on February 1, 7, 8, 10, 14, 15, 16, 21, 22, 25, and 28 of 2015. The resident did not receive AROM on March 1, 7, 8, 11, 14, 15, 20, 21, 22, 27, 28, and 29 of 2015. The Restorative Flowsheet indicated AROM staff was pulled to work the floor and AROM was not completed for Resident #11 on 1/06/2015 and 2/18/2015. 3.1-38(a)(2)(A)			
F 371 SS=E Bldg. 00	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 and interview, the facility failed to prepare and store food under sanitary conditions related to a	F 371	**Whatcorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	05/04/2015

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	potential for physical contamination by cork board fibers and not identifying dented cans. This deficient practice had the potential to affect 64 residents who received meals prepared in the kitchen. Findings include: During the initial kitchen tour, on 4/06/2015 at 7:50 A.M., with Dietary Aide (DA) # 1, the following was observed: 1. In the food preparation area there were two message boards made of wood and cork fibers. The boards were hanging on the wall directly beside the food preparation table. The message boards had several areas of peeling and loose fibers. There were pieces of cork and fibers lying on the floor and lower edge of the preparation table. 2. In the dry food storage area, four large canned goods were observed with dents on the lower side edge. The dents were two inches long and one inch wide. The four canned goods consisted of three cans of Apricots and one can of Mandarin		·Cork boards were disposed of during survey ·Dented cans were removed from kitchen during survey and returned to vendor ·Dietary staff in-serviced on sanitary environment and not placing dented cans on shelf for use by Executive Director and/or designee on 4/29/15. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·Residents who reside in the facility have the potential to be affected by the alleged deficient practice. ·Dietary staff in-serviced on sanitary environment and not placing dented cans on shelf for use by Executive Director and/or designee on 4/29/15. ·Audit was conducted on cans in storage areas by Executive Director to ensure no dented cans were present ·All cork boards in kitchen were disposed of during survey by Executive Director **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Dietary staff in-serviced on sanitary environment and not placing dented cans on shelf for use by Executive Director and/or designee on 4/29/15.	

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	Oranges. During an observation on 4/09/15 at 12:22 P. M., with the dietary manager, the following was observed: 3. The message boards located on the wall by the front food preparation table had three sheets of paper attached with push pins and directly below resting on the floor was one large piece of cork and several fibers. 4. In the dry food storage area, one large can of Pumpkin Cream was located on the second shelf. The can of Pumpkin Cream had a large dent on the bottom edge. During an interview on 4/09/2015 at 2:31 P.M., the Dietary Manager (DM) indicated the message boards should have been removed and there was a potential for particles to fall into the food preparation area. The DM indicated a shipment of canned goods was received yesterday, on 4/08/2015; the Pumpkin Cream can was just received yesterday and was placed on the shelf by accident.		·Audit was conducted on cans in storage areas by Executive Director to ensure no dented cans were present ·All cork boards were disposed of during survey by Executive Director ·Daily audit tool will be completed by Executive Director and/or designee to ensure no dented cans are on shelves for use. ·Audit will be conducted by Executive Director at time of food delivery to ensure no dented cans are placed on shelf; any dented cans will be returned to vendor **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Audit tool will be completed by Executive Director and/or designee daily to ensure no dented cans are on shelves for use ·Sanitization inspection will be completed by Executive Director and/or designee weekly x 4 weeks, monthly x 6 months and quarterly thereafter ·Action plans will be developed and implemented for sanitization score less than 90%	

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	The DM indicated canned goods that are dented should be returned to the supplier and not placed on the shelf. During an interview on 4/10/2015 at 10:00 A.M., the Dietitian indicated small dents on a canned good do not compromise the quality of the food product. The Dietitian had a large can of tomato paste with one inch dents on the top rim and bottom rim that compromised the seam of the can. The Dietitian indicated the product did not appear compromised to her and the dents would not affect the food quality. The Dietician indicated the can of tomato paste would normally be served. The Food Storage policy, dated 2/2002 and identified as current, was provided by the Dietician on 4/10/2015 at 10:22 A.M. and reviewed at that time. Procedure step #5 indicated, "Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods". 3.1-21(i)(2) 3.1-21(i)(3)			

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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 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			

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	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 and record review, the facility failed to ensure proper hand washing by staff when providing care to residents for 4 of 7 residents observed receiving care or assistance in that, hands were not sanitized, gloves were not changed when soiled and hands were not washed after glove removal. (Residents #16, #22, #51, and #55.) Findings include: 1. During an observation of medication administration through a feeding tube on 04/09/2015 at 2:29 P.M., Registered Nurse (RN) #6 pulled out a Kleenex and covered the counter top, placed the syringe, three cups of water, and two cups of medication on the Kleenex. Resident #51 was seated in a wheelchair. RN#6 placed a towel on the lap of Resident #51. RN #6 donned gloves, moved the wheelchair by touching the arms of the wheelchair with her gloved	F 441	**Whatcorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident#16, Resident #22, Resident #51, Resident #55 were not harmed by alleged deficient practice ·Handwashing skills validations for all staff completed between by 5/1/15 ·All staff was in-serviced on infection control related to hand washing, medication administration, linen handling, and peri-care on 4/29/15. ·All staff was in-serviced on wearing gloves and hand hygeine when assisting residents with placing food items in mouth on 4/29/15 ·Peri-care skills validations for all C.N.A.'s completed by 5/1/15 ·Enteral Tube- Medication Administration skills validations for all nurses completed by 5/1/15 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·Residents residing in the facility have the potential to be affected by the alleged deficient	05/04/2015

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	hands. Resident #51 requested to be put to bed. RN #6 called for a Certified Nursing Assistant (CNA) by yelling down the hall. The resident was assisted to bed with the help of Qualified Medication Aide (QMA) #8. RN #6 left her gloves on and took Resident #51's shoes off, then removed her gloves. RN #6 washed her hands for 10 seconds and donned gloves again. RN #6 picked up papers with the written policy and procedure on them to read instructions with gloved hands. RN #6 checked the placement of the feeding tube and checked for residual; there was no residual. RN #6 moved the medication to the bed side table. RN #6 flushed the feeding tube with 30 milliliters (ml) of water, poured the liquid Tylenol in the feeding tube, again flushed with 30 ml of water, poured the liquid lithium (medication) in the feeding tube and flushed the tube with an additional 30 ml of water. RN #6 removed her gloves, used hand sanitizer, and donned a new pair gloves. RN #6 flushed the feeding tube with 30 ml of water, gave 240 ml of Jevity 1.2 cal. (liquid food for tube feeding) and flushed the tube a final time		practice ·Handwashing skills validations for all staff completed by 5/1/15 by Director of Nursing and/or designee ·All staff was in-serviced on infection control related to hand washing, medication administration, linen handling, and peri-care on 4/29/15 by Director of Nursing and/or designee ·All staff was in-serviced on wearing gloves and hand hygiene when assisting residents with placing food items in mouth by Director of Nursing and/or designee on 4/29/15 ·Peri-care skills validations for all C.N.A.'s completed by 5/1/15 by Director of Nursing and/or designee ·Enteral Tube- Medication Administration skills validations for all nurses completed by 5/1/15 by Director of Nursing and/or designee **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·Handwashing skills validations for all staff completed by 5/1/15 by Director of Nursing and/or designee ·All staff was in-serviced on infection control related to hand washing, medication administration, linen handling, and peri-care on 4/29/15 by Director of Nursing and/or	

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	with 120 ml of water. RN #6 washed her hands for 10 seconds then repositioned the covers for Resident #51. 2. An observation was conducted on 04/10/2015 starting at 3:45 P.M. with CNA #4. CNA #4 was observed in the hallway assisting Resident #55. She placed candy, that had fallen out of the resident's mouth and onto the resident's shirt, back into the resident's mouth with her bare hands. CNA #4 then entered the clean linen closet, picked up two washcloths and a towel and exited the linen closet. CNA #4 carried the linens, against her chest, down the hall to Resident #16's room. After entering the room, CNA #4 placed the linens on the resident's chair and left the room to assist Resident #22. The CNA placed Resident #22's left foot back onto the foot rest of the wheelchair and proceeded to transport the resident down the hall. CNA #4 then returned to Resident #16's room, entered the resident's bathroom and turned on the hot water, but did not wash her hands. After turning on the hot water, CNA #4 walked to the window and touched the		designee ·All staff was in-serviced on wearing gloves and hand hygiene when assisting residents with placing food items in mouth by Director of Nursing and/or designee on 4/29/15 ·Peri-care skills validations for all C.N.A.'s were completed by 5/1/15 by Director of Nursing and/or designee ·Enteral Tube- Medication Administration skills validations for all nurses completed by 5/1/15 by Director of Nursing and/or designee ·Director of Nursing and/or designee will conduct rounds every shift to observe peri-care and enteral tube medication administration to ensure infection control practices are followed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·A Resident Care Rounds CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 6 months and quarterly thereafter ·Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met	

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	blinds to look outside and then walked to get the washcloths off of the resident's chair. CNA #5 entered the room, donned gloves, and took the washcloths from CNA #4 who also donned gloves at this time. After getting the washcloths wet, CNA #4 removed the resident's incontinence brief and took one washcloth from CNA #5. CNA #4 wiped from front to back on the left leg crease and then from back to front up the right leg crease. CNA #4 then wiped in a circular motion on the front of the pubic area. CNA #4 repeated the same steps with a clean washcloth to rinse and again with a towel to dry. Both wet and dry washcloths/towels were placed on the bed after use. The resident was rolled on to the right side where CNA #4 used the same washcloths and towel from before to wash, rinse and dry the resident's buttocks in a circular motion. CNA #5 retrieved a brief with her gloved hands and gave it to CNA #4 who then put the brief on the resident. CNA #4 picked up a bottle of lotion, squeezed some out onto her gloved hand, and rubbed it onto the top of the resident's thighs. The dirty linens and trash were bagged separately			

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	and the resident was assisted to dress by both CNAs. After assisting the resident to dress, CNA #4 changed her gloves, and both CNAs assisted the resident into the wheelchair. CNA #4 changed her gloves again, remade the bed, and placed a new lift sheet on the bed. Both CNAs then removed their gloves and left the room with the resident. Hand washing was not observed throughout the entire observation of care. The Hand Hygiene policy, dated 03/2012 and identified as current, was provided by the administrator on 04/09/2015 at 3:15 P.M. and was reviewed at that time. Procedure step #6 indicated after applying soap the staff should use friction for at least 20 seconds during handwashing. 3.1-18(l)			