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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155229 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/02/2015 |
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| F 0000<br><br>Bldg. 00     | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 26, 27, 28, 29, 30, and November 2, 2015</p> <p>Facility number: 000134<br/>Provider number: 155229<br/>AIM number: 100275430</p> <p>Census bed type:<br/>SNF/NF: 67<br/>Total: 67</p> <p>Census payor type:<br/>Medicare: 6<br/>Medicaid: 59<br/>Other: 2<br/>Total: 67</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on November 4, 2015.</p> | F 0000        | 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 any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a Desk Review (compliance) by December 2, 2015 |                      |
| F 0246<br>SS=D<br>Bldg. 00 | 483.15(e)(1)<br>REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES   |               |   |                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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|                    | <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's bed was the appropriate length for the resident's height for 1 of 1 resident reviewed for appropriate bed size. (Resident #21)</p> <p>Findings include:</p> <p>During an observation on 10/26/2015 at 11:29 a.m., Resident #21's feet were against the foot board of his bed.</p> <p>During an observation on 10/27/15 at 11:01 a.m., Resident #21's feet were against the foot board of his bed. During an interview at this time, he indicated he had made comments to the nurses regarding his feet being against the foot board.</p> <p>On 10/29/2015 at 1:39 p.m., the Maintenance Supervisor measured Resident #21's bed. The bed measured 84 inches, and the mattress measured 81 inches.</p> <p>During an interview on 10/29/15 at 2:44 p.m., Resident #21's Power of Attorney</p> | F 0246        | <p>F-246</p> <p>1.Appropriate length of bed for resident #21 was reviewed for resident's appropriate length. Extender was ordered on 10/30/15 and placed on resident's bed on 11/13/15.</p> <p>2.All residents could have the potential to be affected. House wide audit for residents will be done to ensure appropriate length of bed by DON or Designee and will be completed by 12/1/15. See attached audit tool.</p> <p>Re-education to Nursing Staff and Housekeeping Staff by SDC to report residents with in appropriate length of beds to DON, ED, or ADON.</p> <p>Re-education completed by 12/1/15. See attached inservice sheet.</p> <p>3.Resident's height and weight will be reviewed upon admission for appropriate length of bed.</p> <p>4.DON or Designee will bring audits of new admission bed length findings to monthly PI meetings for review X 6 months or until 100% compliance is achieved. See attached audit.</p> <p>5.Completion Date: Dec. 1, 2015.</p> | 12/02/2015           |

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|                    | <p>indicated his father would like a longer bed.</p> <p>During an interview on 10/29/15 at 2:44 p.m., Resident #21 indicated he was unable to move his feet into a relaxed position without bending his knees. Observations at this time were consistent with the resident's statement.</p> <p>During an interview on 10/29/15 at 2:59 p.m., Certified Nursing Assistance #1 indicated Resident #21 had his feet against the foot board during care.</p> <p>During an interview on 10/29/15 at 3:29 p.m., the Director of Nursing indicated the size of the bed for Resident #21 had not been discussed during any Interdisciplinary meetings.</p> <p>On 10/29/15 at 3:35 p.m., information regarding the length of Resident #21's bed was requested.</p> <p>The clinical record of Resident #21 was reviewed on 10/29/15 at 2:25 p.m. Resident #21's diagnosis included, but were not limited to, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, chronic pain, and neuropathy.</p> <p>Resident #21 had a, 10/5/15, quarterly</p> |               |   |                      |

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| F 0329<br>SS=D<br>Bldg. 00 | <p>Minimum Data Set (MDS) assessment which indicated his height was 73 inches. The MDS indicated he had pain, received pain medication. The MDS indicated for bed mobility, the resident needed extensive assistance and 2 person physical assistance.</p> <p>A multidisciplinary team review form indicated an extension of the bed had been ordered. Resident #21 agreed to Occupational therapy when the new extension arrived for his bed.</p> <p>3.1-19(m)(1)</p> <p>483.25(l)<br/>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br/>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to</p> |               |   |                      |

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|                    | <p>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.</p> <p>Based on record review and interview, the facility failed to ensure sliding scale insulin coverage was given correctly for 1 of 5 residents reviewed for unnecessary medications. (Resident #78)</p> <p>Findings include:</p> <p>Resident #78's clinical record was reviewed on 10/28/15 at 9:48 a.m. The resident's diagnoses included but were not limited to, type II diabetes mellitus, hypertension, and depression.</p> <p>The resident's current physician's orders were signed on 9/28/15. The resident had a sliding scale insulin order for Humalog insulin 100 units/ml subcutaneous solution before meals and at bedtime. The order indicated the resident was to receive insulin coverage for the following blood sugars:</p> <p>141-180 = 1 unit<br/>181-220 = 2 units<br/>221-260 = 4 units<br/>261-300 = 6 units<br/>301-340 = 7 units<br/>341-380 = 8 units</p> | F 0329        | <p>F-329 Audit</p> <p>1.Diabetic Administration Record for resident #78 was reviewed specific for Medication Administration for sliding scale coverage. Education completed for LPN #1 and LPN #2.</p> <p>2.All residents with sliding scale coverage orders have the potential to be affected. DON or Designee will audit all sliding scale coverage for accurate coverage for the past 30 days.</p> <p>3.Re-education of Nursing Staff on following physician's orders for sliding scale coverage as per LCCA policy for Medication Administration was completed 11/13/15. DON or Designee will audit the Diabetic Administration record 3X weekly X4 weeks then weekly X 6 months. See attached audit.</p> <p>4.DON or Designee will bring results of audit to monthly PI meetings for review for 7months or until 100% compliance has been achieved.</p> <p>5.Completion Date: Dec. 1, 2015.</p> | 12/02/2015           |

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|                    | <p>381-420 = 9 units<br/>421-460 = 10 units<br/>greater than 460 = 12 units</p> <p>Review of the resident's October, 2015, "Medication Administration Record" indicated the resident had a blood sugar of 228 on 10/12/15 at 4:00 p.m. and 6 units of Humalog insulin sliding scale was given. The resident should have received 4 units of Humalog insulin coverage.</p> <p>The resident had a blood sugar of 140 on 10/29/15 at 4:00 p.m. and the resident received 2 units of Humalog sliding scale insulin coverage. The resident should not have received insulin coverage.</p> <p>During an interview with the Director of Nursing on 10/30/15 at 9:56 a.m., she indicated the resident's blood sugar was 228 on 10/12/15 at 4:00 p.m., and the resident should have received 4 units of Humalog sliding scale insulin. She indicated the resident's blood sugar was 140 on 10/29/15 at 4:00 p.m., and the resident should not have received any insulin coverage.</p> <p>The current, undated "Policies for Medication Administration" was provided by the Director of Nursing on 10/30/15 at 1:20 p.m. The policy</p> |               |   |                      |

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| F 0371<br>SS=F<br>Bldg. 00 | <p>indicated "...All medications are administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis. Policy Responsibility of nursing professional: be aware of the classification, action, correct dosage, and side effects of a medication before administration...."</p> <p>3.1-48(a)(1)</p> <p>483.35(i)<br/>FOOD PROCURE,<br/>STORE/PREPARE/SERVE - SANITARY<br/>The facility must -<br/>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br/>(2) Store, prepare, distribute and serve food under sanitary conditions<br/>Based on observation, interview and record review, the facility failed to ensure staff discarded leftovers after 72 hours, items were stored clean and in good condition, and storage bins were clean. This deficient practice had the potential to effect 67 of 67 residents that received meals from the kitchen.</p> <p>Findings include:</p> | F 0371        | <p>F-371</p> <p>1.This could have the potential to affect all facility residents.<br/>2.No adverse effects or outcomes noted, of residents.<br/>3.Refrigerator and freezer audits were done immediately, to ensure that no outdated leftover items were present (see attached audit tool). New pots and pans, baking sheets etc. were ordered immediately to replace the ones with carbon build up. (see invoice) Lids on the dry storage</p> | 12/02/2015           |

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|   | <p>The initial tour of the kitchen was made on 10/26/15 from 10:06 a.m. to 10:40 a.m., with the Dietary Manager present. There was a large skillet on the stove with bits of egg in it. The Dietary Manager indicated it had been used during breakfast. The inside of the skillet had a heavy dark brown/black coating on the sides of the skillet and the bottom of the skillet was shiny aluminum. The Dietary Manager indicated the dark brown/black sides of the pan were due to carbon build up from using cooking spray.</p> <p>A large colander, stored under the counter as clean per the Dietary Manager, had dried debris and white lime build up on it.</p> <p>There was a plastic container of taco meat, dated 10/19/15 with a use by date of 10/22/15, stored in the refrigerator. The Dietary Manager indicated the meat should have been discarded after 10/22/15.</p> <p>There were three white plastic storage bins in the storage room for dry goods. The lids were greasy to touch. The Dietary Manager indicated the bins had been sitting next to the friers and had recently been relocated to the storage room. She indicated the bins were not on</p> |   | <p>bins were cleaned immediately, to remove any debris or build up. These are now on a regular cleaning schedule. (See attached cleaning schedule and new cleaning template). Dishes were immediately checked, rewashed and dried appropriately, if lime was observed.</p> <p>4.Re-education of Dietary Staff was done on 11/3/15, on the policy and procedure for proper dish drying techniques (see education content ), Policy and procedure for storing and discarding leftovers (see P&amp;P of education content ), cleaning and sanitation policy and procedures of the dietary department (see in service sig sheet, and P&amp;P of educational content ) Audit tools will be done by Food service Manager or Designee 3"x weekly for 3 months and then 2'x weekly for 3 months , to ensure bottoms of pots and pans have been cleaned and are free from heavy carbon build up, dish drying technique52 is followed and there is no presence of lime observed, and to ensure that tops of storage bins are clean and free from debris. To ensure 100% compliance.</p> <p>5.Completion: 12/2/15 Audit tool results will be brought to the monthly QA/PI meetings for review by the committee to ensure ongoing compliance for 6 months.</p> |  |  |   |  |

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|                    | <p>the cleaning schedules.</p> <p>An observation of the kitchen was made on 10/29/15 at 10:41 a.m. to 11:00 a.m., with the Dietary Manager. There was a large bowl shaped colander with white lime build up on it stored as clean. The Dietary Manager indicated the lime build up was due to staff not standing items up to allow for proper drying.</p> <p>There were four large muffin pans, four large cookie sheets and and two large roasting pans with heavy brown build up on them. The Dietary Manager identified the build up as carbon build up.</p> <p>During an interview with the Administrator on 10/29/15 at 3:19 p.m., she indicated 67 residents received meals which were prepared in the facility kitchen.</p> <p>The current, revised 1/1/07, "Food Safety" policy was provided by the Administrator on 11/2/15 at 9:10 a.m. The policy indicated leftovers must be discarded after 72 hours.</p> <p>3.1-21(i)(3)</p> |               |   |                      |

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| F 0465<br>SS=F<br>Bldg. 00 | <p>483.70(h)<br/>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure resident rooms were clean and in good repair for 9 of 17 residents rooms reviewed. (Rooms #10, #12, #22, #24, #33, #34, #36, #54, #55). The facility failed to ensure the facility laundry room, linen closets and the kitchen floor were clean and in good repair. This deficiency had the potential to impact 67 of 67 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Stage 1 observations of resident rooms were made during the following dates and times:</p> <p>Rooms 54 and 55 shared bathroom on 10/26/15 at 11:31 a.m., the bathroom floor had 4 dark color stains that were approximately the size of a coffee saucer, in front of the commode. The threshold had debris build up at the bathroom door.</p> <p>Room 33 on 10/26/15 at 2:46 p.m., at the</p> | F 0465 | <p>F 465</p> <p>1.No adverse effects of residents 10, 12,22,24,33,34,36,54,55 noted.</p> <p>2.This could have the potential to affect other residents, no adverse effects of other residents noted, during room audits.</p> <p>3.Housewide audit done of resident rooms, to review room condition, paint, cove base, doors, ceilings, floors, wallpaper, furnishings. ( see attached room audits ) Rooms 10,12,33,34,36,54,55 had preventative maintenance completed, and other identified rooms as per facility audit have been put on weekly scheduled preventative maintenance list to be completed. ( see attached schedule) Kitchen floor was steam cleaned and protectant sealant coating applied to the floor, to enable easier daily cleaning, on 11/9/15 per Stanley Steamer. (see attached invoice of completion ) Missing dry wall and other items in the laundry room, were repaired by Jackson and son plumbing and heating (see attached invoice date of completion) linen closet floors</p> | 12/02/2015 |
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|                    | <p>entrance wall of bedroom had a large area approximately 2 feet by 2 feet of deep scratches in the plaster with plaster dust on the floor below the area.</p> <p>Rooms 10 and 12 shared bathroom, on 10/27/15 at 10:39 a.m., in the bathroom had chipped plaster, with exposed dry wall behind the sink.</p> <p>Rooms 22 and 24 shared bathroom, on 10/27/15 at 10:45 a.m., in the bathroom had paint scraped off the wall above the cove baseboard next to the toilet.</p> <p>Rooms 34 and 36 shared bathroom, on 10/27/15 at 1:10 p.m., in the bathroom had no toilet paper holder. The wall next to the commode had holes in the wall where the old toilet paper holder had been removed.</p> <p>2. During the environmental tour on 10/29/15 at 10:06 a.m., the Administrator, the Housekeeping Supervisor, and the Maintenance Supervisor observed the following:</p> <p>The laundry room had a hole of missing dry wall. The hole exposed water pipes. The hole was on the wall at the entrance to the laundry room, behind the 2 industrial washers. The area was measured by the maintenance director.</p> |               | <p>were cleaned immediately, and are now on the new cleaning schedule. (see new cleaning Schedule ) New sink and faucet were installed in the Ivy Court Medication room, (see attached invoice) tile in rooms 54-55 bathroom replaced, the Hickory Hall shower room was repaired and replaced where needed. ( see attached invoice of items) The South Hall closet strip was repaired and cleaned.</p> <p>4.Re-education was done on 11/19/15 for the Housekeeping and Maintenance departments on the new room cleaning forms, (see attached sheets) procedure for filling out maintenance requests for room repairs, and routing to maintenance. (see attached sheet) Audit tools/PI implemented for Housekeeping and Maintenance Supervisors or Designee to be done 2'x weekly for 3 months, and then weekly for 3 months.</p> <p>5.Completion: 12/2/15, Audit tools will be reviewed at the monthly QA/PI meetings by the committee to ensure 100% compliance for 6 months.</p> |                      |

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|                    | <p>The area measured 8.5 feet x 16 inches. This area had exposed pipes with a build up of dryer lint adhered to the pipes. This was the only laundry room in the facility.</p> <p>The clean linen closet on the South Hall had debris, dust, and two articles of linen under the shelves on the floor .</p> <p>The clean linen closet on the Hickory Hall had debris and dust build up on the floor under the shelves.</p> <p>The new linen supply closet on the South Hall had insulation particles on the floor and on the open packages of new linen. The strip on the floor at the threshold was loose. The Maintenance Supervisor removed the strip and placed it on top of a box inside the closet.</p> <p>The Hickory Hall shower room had cracked and broken plaster on the left wall at the entrance of the shower stall. This area was next to the floor.</p> <p>The sink in the Medication room on the secured unit had a greenish brown lime stain around the faucet and in the sink.</p> <p>During an interview on 10/29/15 at 11:34 a.m., the Housekeeping Supervisor indicated the new linen supply closet was</p> |               |   |                      |

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|                    | <p>not listed on the cleaning schedule, and the closet did not get inspected unless new linen was needed.</p> <p>During an interview on 10/29/15 at 11:01 a.m., the Maintenance Supervisor indicated the laundry room wall had been open with exposed pipes since June, 2015. He indicated there has been multiple water leaks, and it was easier to keep the wall open to the pipes for repairs.</p> <p>On 10/29/15 at 1:13 p.m., the Maintenance Supervisor provided instructions for "Resident Room Inspections: Resident Room Check - 5 per week". This form included, but was not limited to, "...wall and trim paint: hole patching and wall repair... wallpaper check: repair and or patch... cove base: complete and secure to wall... flooring: secure, free of rips, snags, pulls odor... nurse call for room/bathroom: pull cord clean/proper length/function... plumbing: inspect drywall around inlets/fixtures repair if necessary... bathroom: toilet paper holder secure...."</p> <p>On 10/29/15 at 1:52 p.m., the Housekeeping Supervisor provided "Daily Cleaning Resident Room log" dated October, 2015. This form indicated the clean linen closet were cleaned</p> |               |   |                      |

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|                    | <p>everyday from the 18th through the 28th of October.</p> <p>A "Bed Inventory" completed by the Administrator on 10/26/15 indicated rooms #10, #12, #22, #24, #33, #34, #36, #54, #55 were licensed as 2 bed rooms. The "Bed Inventory" indicated this deficiency has the potential to impact 103 residents.</p> <p>"Facility Census" form completed by the Administrator on 10/26/15 indicated 67 residents resided in the facility.</p> <p>3. The kitchen was observed on 10/26/15 at 10:06 a.m., and on 10/29/15 at 10:41 a.m., with the Dietary Manager present during both observations. The white grout lines between the tiles of the kitchen floor were soiled and black looking. The Dietary Manager indicated she had been told they were getting estimates to have the floor cleaned and sealed.</p> <p>During an interview with the Administrator on 10/29/15 at 3:19 p.m., she indicated 67 residents received meals which were prepared in the facility kitchen.</p> <p>3.1-19(f)</p> |               |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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