

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00160822.</p> <p>Complaint IN00160822 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F323, and F327.</p> <p>Survey dates: December 15, 16, 17, 18, 22, 23, 2014</p> <p>Facility number: 000327 Provider number: 155561 AIM number: 100273920</p> <p>Survey team: Denise Schwandner, RN TC Diane Hancock, RN (December 15, 16, 17, 18, 22, 2014) Barbara Fowler, RN (December 16, 17, 18, 2014) Diana Perry, RN Anna Villain, RN Sylvia Scales, RN (December 22, 23, 2014)</p> <p>Census bed type: SNF/NF: 71 Total: 71</p>	F000000	<p>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 this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after January 19th 2015 The Facility is requesting face to face IDR with F 323 and F327 as facility disagrees with scope and severity.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000256 SS=D	<p>Census payor type: Medicare: 11 Medicaid: 49 Other: 11 Total: 71</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 30, 2014 by Jodi Meyer, RN</p> <p>483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to ensure the residents had adequate and comfortable lighting levels in all areas, for 3 of 31 resident rooms reviewed, in that the rooms measured less than 10 foot candles of illumination. (241B, 220A and 407A.)</p> <p>Findings include</p> <p>On 12/16/14 during Stage 1 observation and resident interview :</p> <p>In rooms 214 B, 220 A and 407 A each resident complained of not having</p>	F000256	<p>It is the practice of this provider to ensure that all alleged violations involving Adequate and comfortable lighting levels are in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>·The lighting in rooms 214b, 220A, and 407a has been evaluated by the maintenance supervisor. Appropriate lighting has been placed in these listed rooms.</p> <p>2: How other residents having the potential to be</p>	01/19/2015

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	<p>enough light in their rooms.</p> <p>On 12/22/14 9:00 A.M. -10:00 A.M., the same rooms were revisited and the light illumination was checked. The lighting in each room, under the direct light, was over 30 foot candles, the light was less than 10 foot candles in center of the room and the opposite wall.</p> <p>On 12/22/2014 at 2:57 P.M.the Head of Maintenance indicated he would change to higher watt bulb and see if this would help. He had changed the bulbs in all facility recently. The bulbs were changed and measured again which indicated the same reading of less than 10 footcandles of illumination.</p> <p>On 12/23/14 at 10:50 A.M. a policy was received from Head of Maintenance, titled "Weekly Tasks/Verify Proper Operations" which indicated on a weekly basis what areas are concentrated on for the month.</p> <p>3.1-19 (dd)</p>		<p>affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> ·All residents who reside in the facility have the potential to be affected by the alleged deficient practice. ·The maintenance supervisor will complete a house audit evaluating all lighting in resident rooms. Rooms needing additional lighting will be logged and scheduled for repair. ·The Executive director or designee educated the maintenance supervisor on appropriate lighting in resident rooms on or before Jan 19th 2015. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·The Executive director or designee educated the maintenance supervisor on appropriate lighting in resident rooms on or before Jan19th 2015 ·The facility department heads will completedaily rounds Monday thru Friday and report any environmental findings in regards to poor lighting in the afternoon CQI meeting. The weekend house supervisor will make rounds on Saturday and Sunday and report abnormal findings to the executive director. These findings will be logged in the maintenance repair log and 		

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the		<p>audited daily to ensure they are completed.</p> <ul style="list-style-type: none"> ·The facility has created a maintenance evaluation schedule. The maintenance director will evaluate facility areas on a scheduled basis ensuring they present with adequate lighting. Areas identified that are in need of increased lighting will be logged and scheduled for repair. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> ·An Environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month and monthly for 5 months by the maintenance supervisor or designee. ·The Environmental CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. ·Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. <p>Date of Compliance 1/19/2015.</p>		

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	<p>assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>Based on observation, interview, and record review, the facility failed to ensure a care plan was developed for 2 of 5 residents who met the criteria for review of unnecessary medications, in that, a care plan was not developed for behaviors associated with the use of an antipsychotic medication. (Resident #98, Resident #57)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #98 was reviewed on 12/17/2014 9:10 a.m. The record indicated the diagnoses including, but were not limited to, mixed dementia with behavior disturbance, gout, CVA, asthma, pacemaker, BPH,</p>	F000279	<p>It is the practice of this provider to ensure that all alleged violations involving Develop Comprehensive Care Plans are in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>The Care Plan of resident #98 and #57 was updated identifying the type of behavior the residents exhibited for the use of their antipsychotic medication and interventions to be provided when the behaviors are exhibited. A behavior monitoring flow sheet was also initiated for these residents</p> <p>2: How other residents having the potential to be</p>	01/19/2015

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	<p>hearing loss, hyperlipidemia, hypothyroidism, and history of skin cancer.</p> <p>The MAR (medication administration record) dated 12/1/14 through 12/31/14 indicated Resident #98s medications included, but were not limited to, Haldol (an antipsychotic medication) 5 mg (milligrams) IM (intramuscular) every 8 hours, Ativan (an antianxiety medication) 2 mg IM every 8 hours alternate with Haldol prn (as needed) extreme agitation, and Xyprexa (an antipsychotic medication) 10 mg po daily if patient refuses po (by mouth), give Zyprexa 10 mg IM daily.</p> <p>Nurses notes indicate that the resident has had numerous episodes of behavior from admission until 12/16/14 when he had a sudden decline in condition. The clinical record lacked any documentation related to a plan of care for behaviors.</p> <p>The nurses notes included, but were not limited to: 12/6/14 "Resident slamming peanut butter and jelly sandwich down on desk, CNA tried to redirect, then gave resident a cookie resident slammed cookie down on desk, punched it, then picked it up and threw it. Then lunged toward CNA and was trying to hit staff several times.</p>		<p>affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> ·All residents who reside in the facility and receive antipsychotic medications have the potential to be affected by this alleged deficient practice. ·The Social Services dept and IDT team will be re-educated on the facilities behavior monitoring program, care planning for residents who receive antipsychotic medications, and behavior monitoring sheets by the Social Service Director or designee on or before Jan 19th 2015. ·The CEC or designee will educate facility nurses on behavior monitoring flow sheets and the behavior monitoring program on or before 1-19-2015 ·The Social Service Director or designee will audit and identify all residents who receive an antipsychotic medication. Any resident who receives an antipsychotic medication will have a care plan initiated identifying the behaviors exhibited for the use of the medication and interventions to be provided. A behavior monitoring flow sheet will also be initiated. This audit will occur on or before 1-19-2015 <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p>				

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	<p>Physician and family to be notified tomorrow on dayshift. DNS aware." 12/12/14 at 11:37 a.m. "Resident slammed silverware on the table. Resident had been wandering. Resident urinated in the hallway and spit on the floor. Resident threw a spoon at CNA." At 2:55 p.m. "Patient was requiring IM injections of Haldol due to continued very aggressive behaviors. He last had IM injection on 12/6/14." 12/14/14 at 4:14 p.m. "Resident throwing paper at other resident then lunging toward resident as though to hit her. Staff intervened and resident then lunged at staff. Staff tried to redirect with a snack, and activity, and a drink these attempts were unsuccessful. Resident threw water on staff and then threw a dining room chair." 12/15/14 at 9:56 a.m. "Resident was wandering into other resident's rooms, yelling, pushing at staff, spitting on floor, and resisting care by staff. Also, resident spit out medications on the floor. Resident does not tolerate redirection well."</p> <p>An interview on 12/17/2014 at 9:43 a.m. with LPN #2 indicated the resident had a recent decline and all medications except for PRN Ativan, PRN Morphine, and Rocephin had been discontinued.</p>		<ul style="list-style-type: none"> · Upon admission the facility IDT team will review the residents chart identifying any behaviors and antipsychotic medications. If a resident is identified having behaviors and or is on an antipsychotic medication for behaviors a behavior care plan and behavior monitoring flow sheet will be developed and initiated. The IDT reviews all physician orders and new behavioral events during morning meeting. The Social Services department will ensure all residents with new orders for antipsychotics and those with new or worsening behaviors have a behavior care plan and behavior monitoring flow sheet in place or initiated. · The Social Services dept and IDT team will be re-educated on the facilities behavior monitoring program, care planning for residents who receive antipsychotic medications, and behavior monitoring sheets by the Social Service Director or designee on or before Jan 19th 2015. · The CEC or designee will educate facility nurses on behavior monitoring flow sheets and the behavior monitoring program on or before 1-19-2015 · 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place · A Behavior Monitoring CQI 				

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	<p>On 12/18/2014 1:55 p.m. Resident #98 was observed in his room sleeping in a recliner.</p> <p>On 12/22/14 at 2:20 p.m. the Administrator provided a behavior flow sheet. She indicated that the flow sheet is used as the care plan with interventions addressed. The flow sheet start date is 12/1/14 and the resident was admitted on 12/3/14. The flow sheet also has no behaviors noted.</p> <p>On 12/22/2014 10:17 a.m. Resident #98 was observed resting quietly in bed.</p> <p>An interview with the Administrator on 12/23/14 at 9:25 a.m. indicated she was unable to find a care plan or flow sheet with behaviors noted.</p> <p>2. On 12/17/14 at 9:04 a.m., Resident #57 was observed sitting in the activity area.</p> <p>On 12/17/14 at 1:16 p.m., Resident #57's clinical record was reviewed. Resident #57 was admitted 11/21/14. Resident #57's diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>The most recent signed physician's recapitulation orders, signed 12/1/14,</p>		<p>audit tool will be completed for six months with audits being completed once weekly for one month and monthly for 5 months by the Social Services Director or designee.</p> <ul style="list-style-type: none"> The Behavior Monitoring CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. <p>Date of Compliance 1/19/2015.</p>	

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	<p>included, but were not limited to, Quetiapine (an antipsychotic medication) 25 mg (milligrams), take 1/2 (half) tablet (12.5 mg), by mouth, daily in the morning.</p> <p>The 14-Day MDS (Minimum Data Set) Assessment, dated 12/3/14, indicated, Resident #57 had delusions and hallucinations. The MDS further indicated the resident received an antipsychotic medication 7 out of 7 days prior to the assessment.</p> <p>The record lacked a plan of care identifying the type of behavior the resident exhibited for the use of the antipsychotic medication or interventions to be provided when the resident exhibited any behaviors.</p> <p>On 12/22/14 at 9:26 a.m., Resident #57 was observed in the dining room, seated at a table with other residents.</p> <p>On 12/22/14 at 10:33 a.m., the DON indicated Resident #57 would sometimes talk to herself. The DON further indicated the resident had some delusions and hallucinations.</p> <p>On 12/22/14 at 10:36 a.m., the Memory Care Director indicated Resident #57 did not exhibit behaviors. The Memory Care</p>			

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	<p>Director further indicated Resident #57 was admitted with the antipsychotic medication. The Memory Care Director indicated at a previous facility, Resident #57 had been combative with staff. The Memory Care Director indicated residents who are prescribed an antipsychotic medication require a flow sheet and a plan of care for interventions regarding the resident's particular behavior. The Memory Care Director further indicated a flow sheet had not been initiated for Resident #57 because the resident had not had any behaviors.</p> <p>On 12/22/14 at 2:19 p.m., the Administrator indicated the flow sheets intitiated for behaviors were also the plan of care for the resident's behavior. The Administrator further indicated there was not a flow sheet for Resident #57.</p> <p>On 12/23/14 at 10:55 a.m., the Administrator provided the "Psychotropic Medication Management Program" policy, no date. The policy indicated, "All residents who are taking (either routinely or as needed) antipsychotic, anxiolytic, sedative/hypnotic, or anticonvulsant medication (not used for seizures) are required to have a behavior monitoring program in place to identifying targeted behavioral symptoms being monitored as well as personalized</p>						

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F000309 SS=D	<p>non pharmacological interventions..."</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to identify and monitor an area of skin impairment and/or monitor a resident following the discontinuation of an anticonvulsant. (Resident L, Resident A)</p> <p>Findings include:</p> <p>1. On 12/22/2014 at 9:25 AM, Resident A was observed lying in bed with her eyes closed. The clinical record for Resident A was reviewed on 12/22/14 at 9:50 A.M., diagnoses include, congestive heart failure, tremor and dementia.</p> <p>The signed physicans orders were reviewed an included Phenytonin (Dilantin) 100mg BID and Phenytonin 150mg at bedtime.</p>	F000309	<p>It is the practice of this provider to ensure that all alleged violations involving Provide Care/services for highest well being are in accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <ul style="list-style-type: none"> ·ResidentA's no longer resides in the facility ·ResidentL's skin has been reassessed. The findings have been documented on the weekly summary form. Any open areas have had anew skin event implemented, MD and family notification, and a tx if indicated. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> ·All residents who have a medication change requiring 	01/19/2015

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	<p>Orders dated 11/4/14 included discontinue Dilantin.</p> <p>A nursing note dated 11/7/14 at 5:04 P.M., included, Resident fell in dining room. Resident is ad lib. When staff turned around they found resident falling and resident hit the back of her head on the floor. Resident fully dressed with facility slipper socks on. Resident appears to have uncontrolled jerking of the knees at this time. PT called to evaluate.</p> <p>An IDT note dated 11/10/14 indicated resident was up ambulating with knees jerking et fell back striking head on floor. Res has diagnosis of tremors. Doctor notified new orders revived for labs therapy to asses et to monitor resident.</p> <p>The care plans include, but were not limited to, Resident is at risk for fall due initiated 5/16/13, the interventions include, non skid foot wear at all times added 3/31/14, call light in reach, environmental changes: dry floor, clean and clutter free, personal items within reach all initiated 5/16/13.</p> <p>A care plan indicating Resident has risk for injury related to seizure activity, initiated 5/16/13 the interventions were medications as orders, labs as ordered,</p>		<p>monitoring and or residents with new open areas have the potential to be affected by this alleged deficient practice.</p> <ul style="list-style-type: none"> ·Licensed nursing staff was in-serviced by Clinical Education Coordinator on or Before Jan 19th, regarding weekly skin assessments, skin management program, hot charting, and monitoring of medication changes. ·The facility IDT team was re-educated by the CEC or designee on or before Jan 19th 2015 regarding hot charting events and monitoring of medication changes. ·The facility will complete an audit by completing a facility wide skin sweep identifying any open areas on the resident's. The resident's weekly summary will be updated, a new skin event initiated if applicable, MD and family will be notified and a treatment will be obtained if applicable. ·The facility will complete and audit of resident charts to identify any resident with a recent medication change requiring monitoring. A hot charting event will be opened for all residents who have had a recent medication change needing monitoring. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p>	

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	<p>notify md of any symptoms of seizure activity, observe for symptoms of seizure activity, jerking movements of extremities, body stiffening.</p> <p>The facility provided Lippincott Nursing Drug Handbook dated 2011 included on page 573 "Don't stop drug suddenly because this may worsen seizures."</p> <p>During an interview on 12/23/14 at 8:37 A.M. she indicated if a resident who had been taking an anticonvulsant and the medication was discontinued or they would be placed on "hot charting" or daily monitoring. She indicated that Resident A was not placed on this charting. She further indicated a resident receiving a reeducation of an anticonvulsant would be at a higher risk for falls.</p> <p>12/23/14 at 5:01 P.M., the DON indicated there was no policy related to monitoring of a resident following discontinuation of a medication.</p> <p>2. On 12/16/14 at 9:46 a.m., Resident L was observed in the activity area with a small, eraser sized open area to the right cheek.</p> <p>On 12/17/14 at 9:02 a.m., Resident L was observed in the activity area with a</p>		<p>·Licensed nursing staff was in-serviced by Clinical Education Coordinator on or Before Jan 19th, regarding weekly skin assessments, skin management program, hot charting, and monitoring of medication changes.</p> <p>·The facility IDT team was re-educated by the CEC or designee on or before Jan 19th 2015 regarding hot charting events and monitoring of medication changes.</p> <p>·When a nurse receives a new physician order change for a medication change she will determine if there is a need for monitoring. If monitoring of the medication change is required the nurse will initiate a hot charting event for the symptoms to be monitored. The IDT team will review the previous days orders Monday through Friday. The IDT will identify any medication changes that need monitoring and ensure a hot charting event was initiated. The weekend supervisor or designee will review orders on Saturday's and Sundays ensuring appropriate hot charting events were opened.</p> <p>·The nurses will complete a weekly skin assessment and document their findings in the weekly summary. The nurse will open a new skin event for any new open areas, notify the family and MD, and obtain a treatment order if applicable. The IDT will review all new events Monday</p>				

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	<p>small, eraser sized open area to the right cheek area. The area surrounding the open area was observed to be reddened.</p> <p>On 12/18/14 at 1:15 p.m., Resident L was observed in the dining room, the open area to the right cheek was observed.</p> <p>On 12/22/14 at 9:26 a.m., Resident L was observed in the dining room area. The area on Resident #74's right cheek was observed to be smaller in size and the reddened area surrounding the open area had subsided.</p> <p>On 12/18/14 at 10:37 a.m., Resident L's clinical record was reviewed. Resident #74's diagnoses included, but were not limited to, dementia with behaviors.</p> <p>The Medication Administration orders lacked a treatment or monitoring of the area to Resident L's cheek.</p> <p>The Weekly Summary, dated 12/18/14, indicated there were not any areas of alteration in Resident L's skin integrity.</p> <p>The care plans included, but were not limited to: Resident is at risk for skin breakdown due to dementia, interventions included, but were not limited to, assess and document skin condition weekly and as</p>		<p>through Friday and ensure the appropriate documentation was initiated. The house supervisor will review any skin events on Saturdays and Sundays ensuring the appropriate documentation. The Nursing Management team will complete monthly skin sweeps ensuring all open areas have been identified and documented appropriately.</p> <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p> <ul style="list-style-type: none"> ·A skin tears CQI audit CQI tool will be completed for six months with audits being completed once weekly for one month and monthly for 5 months by the Social Services Director or designee. ·Medication Change Monitoring audit CQI tool will be completed for six months with audits being completed once weekly for one month and monthly for 5 months by the Social Services Director or designee ·The skin tears and Medication Change CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. ·Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. 				

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	<p>needed.</p> <p>On 12/22/14 at 10:36 a.m., the Memory Care Director indicated she had questioned Resident L about the area and the resident thought it could have been nicked with the resident's fingernails.</p> <p>On 12/22/14 at 10:50 a.m., LPN #1 indicated all skin areas are noted by the nurse and followed weekly by the wound team.</p> <p>On 12/22/14 at 11:24 a.m., the DON indicated no events for Resident L's skin conditions were in the clinical record.</p> <p>On 12/22/14 at 2:12 p.m., the DON indicated they had followed up on Resident L's skin area.</p> <p>On 12/23/14 at 4:15 p.m., the Administrator in Training, provided the "Skin Management Program", updated 9/2014. The policy included, but was not limited to: "Weekly skin assessments will be completed on all residents..." "Alterations in skin integrity will be reported to the physician and family members." "All alterations in skin integrity will be documented in the EMR."</p>		-Date of Compliance 1/19/2015.				

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F000323 SS=G	<p>This Federal tag relates to Complaint IN00160822.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents reviewed for falls, in the sample of 5 who met the criteria, had fall preventions in place at the time of a fall. The resident fell walking to the bathroom resulting in a fractured hip. (Resident B)</p> <p>Finding includes:</p> <p>Resident B clinical record was reviewed on 12/18/14 at 9:19 a.m. The resident was originally admitted to the facility 10/30/14 with diagnoses including, but not limited to, hyponatremia, syncope, respiratory failure, and bacterial pneumonia.</p> <p>Progress notes included, but were not limited to, the following: 10/30/14 11:32 p.m. "Resident on pad</p>	F000323	<p>The Facility is requesting face to face IDR with F 323 as facility disagrees with scope and severity. It is the practice of this provider to ensure that all alleged violations involving Free of accident Hazards/supervision/devices are in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>Resident B no longer resides in the facility and was not a resident of the facility by the end of the survey visit.</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>All residents who admit to the facility or at risk for falls have the potential to be affected by the</p>	01/19/2015

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	<p>alarm to bed and chair r/t [related to] fall history. Resident alert and oriented to person,place, and time...resident utilizing of w/c [wheelchair] and rolling walker along with staff assist as weakness to lower limbs and stooped over gait observed during toileting..."</p> <p>11/1/2014 8:55 a.m., indicated, "CNA reported to this nurse that resident was found sitting on floor. Upon entering resident's room this nurse noted that resident was seated on her buttocks next to her bed. Resident stated that she had gotten up to go to the restroom and got light headed and fell. Resident denied hitting her head; however, examination revealed a small laceration to back of resident's head. Blood also found on the floor next to the resident's bed. Resident stated that her hip was 'sore.' Upon assessment external rotation to right leg; altered range of motion. MD notified....Transfer to [hospital]..."</p> <p>11/3/14 11:36 a.m. "IDT [interdisciplinary team] met to review res fall on 11/1/14. Res was found on floor next to bed c/o hip pain et bleeding from head. Upon assessment res had external rotation of R [right] leg et altered ROM [range of motion]. Res stated when she got up to go to restroom she got up et became light headed et fell. Resident is</p>		<p>same alleged deficient practice.</p> <ul style="list-style-type: none"> ·Facility staff will be educated on fall prevention, fall interventions, and the fall program by the CEC or designee on or before 1/19/15 ·An audit will be performed by DNS or designee on all residents who had a fall and or admitted within the last 30 days to ensure appropriate fall interventions are in place per the resident's CP. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·Upon admission the facility IDT team will review the residents chart identifying the residents fall risks. The IDT team will ensure appropriate interventions are placed in the resident's room and that the fall Care plan is updated. · The facility nursing staff will round each shift ensuring current fall interventions are in place per the residents care plan/ profile. ·Facility staff will be educated on fall prevention, fall interventions, and the fall program by the CEC or designee on or before 1/19/15 ·DNS or designee will conduct rounds every shift to ensure fall interventions are in place per the residents care plan and profile. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</p>	

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	<p>new to facility et was not yet acclimated to surroundings et routine. Resident does have dx [diagnosis] of syncope. Family et doctor notified. Resident was sent to [hospital] for further treatment. IDT feels root cause is resident attempted to take self to restroom with out calling for assistance to restroom. Intervention put in place is awaken at night et toilet resident. Therapy to evaluate upon return. Other interventions in place are call light in reach floors clean et clutter free non skid foot wear pad alarm in bed et chair therapy to screen..."</p> <p>The admission history and physical from the hospital, dated 11/1/14, indicated the resident was admitted for treatment of a fractured right hip.</p> <p>Fall event documentation included the following: 11/1/14 05:10 a.m. Unwitnessed fall Had been in bed with oxygen (O2) 2 liters per nasal cannula Found on floor on buttocks beside bed Pajamas on, bare feet, O2 off-laying on bed Pain right hip and leg Hit head On anticoagulant History of orthostatic hypotension Head pressure dressing, immobilized hip</p>		<ul style="list-style-type: none"> ·A fall management CQI audit tool will be completed for six months with audits being completed once weekly for one month and monthly for 5 months by the DNS or designee. ·The fall management CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. ·Deficiency in this practice will result disciplinary action up to and including termination of the responsible employee. ·Date of Compliance 1/19/2015. 	

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	<p>Resident stated that she got up to go to the bathroom and got light headed and fell</p> <p>Was incontinent at time of fall</p> <p>Intervention put in place to prevent another fall: "Night shift to toilet resident more often. Therapy to screen when resident returns."</p> <p>The resident had a care plan, initiated on 10/30/14, for being at risk for falls. The care plan was current as of 12/18/14.</p> <p>Interventions included, but were not limited to, the following:</p> <p>10/30/14 call light in reach</p> <p>10/30/14 Environmental changes: floors clean and clutter free</p> <p>10/30/14 Non skid footwear</p> <p>10/30/14 at risk for fall care plan</p> <p>10/30/14 personal items in reach</p> <p>10/30/14 Therapy screen as ordered</p> <p>11/1/14 Staff will toilet resident before meals or after meals upon rising at bedtime et through the night every 4 hours.</p> <p>11/10/14 Alarming floor mat at bedside.</p> <p>Physician's orders indicated the pad alarm to the bed and chair had been discontinued on 11/19/14.</p> <p>On 12/18/2014 at 10:56 a.m., Resident B was observed to be seated on the side of her bed. The floor pad alarm was in</p>			
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	<p>place and working.</p> <p>On 12/18/2014 at 3:29 p.m., the Director of Nurses (DON) was interviewed about falls. She indicated she couldn't find any reference to the alarm. Doesn't remember if that was looked at or not. She indicated if a resident was known to turn off an alarm, they usually added an alarm or put the alarm box out of reach.</p> <p>On 12/18/14 at 4:16 p.m., the DON provided an in-house fall review tool. The documentation indicated the resident was noncompliant with asking for assistance and was known to turn alarms off. The DON indicated that was why they added the alarming mat at the bedside when the resident returned from the hospital.</p> <p>On 12/22/14 at 3:10 p.m., the DON provided the Fall Management Program policy, dated 7/01, revised 9/2013. She indicated the pad alarms were being used as an intervention for new admissions, but Resident B had been noncompliant and turned the alarm off.</p> <p>The policy included, but was not limited to, the following: "All new admissions will be considered at fall risk based upon his/her new living arrangements, and his/her reasons for</p>				

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F000327 SS=G	<p>being admitted in to the nursing facility. -All staff members will be notified of new admissions per facility specific policy. -Nursing staff will assess the resident and environmental conditions every shift for the 1st 3 days and/or as directed by the DNS [Director of Nursing Services] /designee..." This Federal tag relates to complaint IN00160822.</p> <p>3.1-45(a)(2)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident at risk for dehydration, received adequate fluids to prevent dehydration, in that, a resident with impaired cognition and decreased fluid intake and output, was not monitored adequately and the physician was not notified. This deficient practice resulted in a resident being hospitalized with severe dehydration, acute renal failure, and respiratory failure. (Resident A)</p>	F000327	<p>The Facility is requesting face to face IDR with F 327 as facility disagrees with scope and severity. It is the practice of this provider to ensure that all alleged violations involving sufficient fluid to maintain hydration are provided in accordance with State and Federal law through established procedures. 1. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Resident A no longer resides in the facility 2. How will you identify other</p>	01/19/2015

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	<p>Findings include:</p> <p>On 12/22/2014 at 9:25 a.m., Resident A was observed lying in bed with her eyes closed.</p> <p>The clinical record for Resident A was reviewed on 12/22/14 at 9:50 a.m., diagnoses included, but were not limited to, congestive heart failure, tremor, dementia, dysphasia, and hypertension. A hospital history and physical dated 12/6/14 included, Reason for admission: "Acute toxic metabolic encephalopathy, acute renal failure". The hospital report also included lab results that included, but were not limited to, BUN 50, Creatinine 3.21.</p> <p>Another section titled "ASSESSMENT AND PLAN " included, but was not limited to: "1. Acute renal failure, prerenal [sic], from severe dehydration. The patient's renal function was normal just 2 weeks ago and now comes with a creatinine of 3.21 and BUN of 50 as well as hyperkalemia (high potassium). She has been on morphine, lethargic for over 2 weeks and has not been drinking enough or eating and all this leading to prerenal [sic] azotemia [high BUN] At this time will put in a Foley catheter, aggressively will hydrate with IV fluids, monitor urine output and BMP [basic metabolic profile]". Also included in the</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who reside in the facility have the potential to be affected by the alleged deficient practice. ·Facility nursing staff will be educated on hydration,s/s of fluid imbalance, documentation of fluid intakes, reporting of decreased intakes, and MD notification by the CEC or designee on or before 1/19/15. ·The facility ran a report and audited all resident's fluid intakes for a 3 day period. Any resident with decreased fluid intakes was identified, the MD and family were notified, and the residents plan of care was updated with new interventions to ensure the residents hydration needs are met. <p>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> ·Facility nursing staff will be educated on hydration,s/s of fluid imbalance, documentation of fluid intakes, reporting of decreased intakes, and MD notification by the CEC or designee on or before 1/19/15. ·The facility will complete a hydration assessment upon admission/readmission, with significant change, and quarterly. The IDT team will review the 		

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	<p>hospital history and physical was,"4. Acute respiratory failure with hypoxemia secondary to altered mental status (lethargy). The patient also has underlying chronic obstructive pulmonary disease. Will continue with bronchodilator treatment every 6 hours, supplemental oxygen as needed to maintain her oxygen saturation between 89% and 92%".</p> <p>The care plans included, but were not limited to, dehydration and fluid maintenance initiated 2/19/14, the interventions included: provide nectar thick liquids added on 10/14/14, document and notify MD of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decrease blood pressure, weak rapid pulse, change in mental status, decreased urine output, abnormal labs and poor skin turgor, encourage fluids, labs as ordered and record intake initiated on 2/13/14.</p> <p>A nutritional risk assessment completed by the Registered Dietician dated 8/27/14 included, but was not limited to, "Estimated fluid needs >[more than] 1610 cc/d (cubic centimeters daily)".</p> <p>The labs for Resident A were reviewed and included, but were not limited to,</p>		<p>hydration assessments and if the resident is at significant risk for hydration issues a hydration plan will be developed and care planned.</p> <ul style="list-style-type: none"> When a resident experiences a decrease in fluid intakes the nurse will assess the resident and will notify the physician and family. The nurse will document anursing note with assessment findings, notifications, and actions taken. The resident will then be placed significant change hydration hot charting in which an assessment will be performed and documented each shift until the condition has stabilized. The Nurse Management team will run a hydration report daily and review all residents' fluid intakes for the previous day. Residents who have decreased intakes will be assessed, have their family and MD notified, and have new hydration interventions implemented if applicable. The house supervisor or designee will review the facility hydration report on Saturdays and Sundays ensuring appropriate hydration follow upoccurs. <p>4. 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?</p> <ul style="list-style-type: none"> A hydration CQI audit tool will be completed for six months with audits being completed once weekly for one month and then monthly for 6 months by a nurse 	

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	<p>11/7/14 BUN (blood urea nitrogen) 22 reference range (normal level) listed as 8-23, creatinine 0.8 and the reference range (normal level) listed as 0.4-1.1. Labs dated 11/24/14 included, BUN 29<H> (high) reference range (normal levels) listed as 8-23, Creatinine 0.9 reference range (normal levels) 0.4-1.1.</p> <p>Resident A's fluid intake was reviewed and were as follows: 11/21/14 fluid intake was 720ml, 890ml less than suggested intake. 11/22/14 fluid intake was 840ml, 770ml less than suggestion intake. 11/23/14 fluid intake was 1080ml, 530 ml less than suggested intake. 11/24/14 fluid intake was 710ml, 900 ml less than suggested fluid intake. 11/25/14 fluid intake was 600ml, 1010ml less than suggested fluid intake. 11/26/14 fluid intake was 900 ml, 710ml less than suggested fluid intake. 11/27/14 fluid intake was 1080ml, 530 ml less than suggested fluid intake. 11/28/14 fluid intake was 1080ml, 530 ml less than suggested fluid intake. 11/29/14 fluid intake was 1080ml, 530 ml less than suggested fluid intake. 11/30/14 fluid intake was 600ml, 1000 ml less than suggested fluid intake. 12/1/14 fluid intake was 840ml, 770ml less than suggested fluid intake.</p>		<p>manager or designee ·A hydration CQI tool will be reviewed monthly bythe CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. ·Deficiency in this practice will result indisiplinary action up to and including termination of the responsible employee. ·Date of Compliance 1/19/2015.</p>	

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	<p>12/2/14 fluid intake was 1680ml, resident met suggested fluid intake.</p> <p>12/3/14 fluid intake was 1320ml, 280 ml less than suggested fluid intake.</p> <p>12/4/14 fluid intake was 1440 ml, 170 ml less than suggested fluid intake.</p> <p>12/5/14 fluid intake was 960ml, 650ml less than suggested fluid intake.</p> <p>The record lacked documentation the resident refused fluids when offered.</p> <p>Resident A's urine output record was reviewed and included:</p> <p>11/21/14 medium urine output documented at 9:24 p.m.,</p> <p>11/22/14 no documented urine output</p> <p>11/23/14 no documented urine output</p> <p>11/24/14 medium urine output at 4:23 p.m.</p> <p>11/25/14 medium urine output at 10:31 p.m.</p> <p>11/26/14 medium urine output at 12:03 a.m.</p> <p>11/27/14 medium urine output at 4:44 p.m.</p> <p>11/28/14 no urine output documented</p> <p>11/29/14 no urine output documented</p> <p>11/30/14 large urine output documented at 4:20 p.m.,</p> <p>12/1/14 medium urine output documented at 12:52 a.m. and a Large Urine output at 10:03 p.m.</p> <p>12/2/14 medium urine output documented at 4:37 p.m.</p>						

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	<p>12/3/14 no documented urine output 12/4/14 medium urine output at 4:12 p.m. 12/5/14 medium urine output at 3:59 p.m.</p> <p>During an interview on 12/23/13 at 8:37 a.m., the Director of Nursing (DON) indicated all residents fluid intakes were tracked in the matrix system. She further indicated they would monitor residents for decreased fluid intake and notify the physician as necessary. The DON was unable to provide documentation that the physician for Resident A had been notified of her decreased fluid intake.</p> <p>A policy titled "Hydration Management" dated June 2014 was on 12/23/14 at 3:49 p.m., it included, but was not limited to, "1. Resident's Hydration status will be assessed upon admission or readmission, with significant change and quarterly utilizing the IDT Hydration Review. Any resident with identified risk factors will be assessed by the IDT and documentation will be placed in the EMAR IDT hydration review observation to include but not limited to: a. Resident's risk factors for dehydration, b. resident ' s current fluid intake, c. resident's self performance with fluids, d. physical assessment including mucous membranes, skin turgor, and f. plan for hydration. "</p>			

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F000328 SS=D	<p>This Federal tag relates to complaint IN00160822.</p> <p>3.1-46(b)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to provide an assessment for 1 of 1 resident reviewed for nebulizer treatments. (Resident #79)</p> <p>Findings include:</p> <p>The clinical record for Resident #79 was reviewed on 12/17/14 at 8:53 a.m. Resident #79 had diagnoses including, but not limited to, asthma, Parkinson's disease, COPD (chronic obstructive pulmonary disease), morbid obesity, bipolar disorder, depressive disorder, GERD (gastroesophageal reflux disease), and thyroid disease.</p>	F000328	<p>It is the practice of this provider to ensure that all alleged violations involving treatment/care for special needs are in accordance with State and Federal law.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <ul style="list-style-type: none"> ·Resident#79 was provided a new nebulizer flow sheet, was provided a nebulizer treatmentper order and the appropriate assessments were documented. ·Thefacility nurses will be educated on nebulizer administration, assessments, and documentation on or before Jan 19th 2015 by the CEC or designee <p>2: How other residents having</p>	01/19/2015

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	<p>The admission MDS (Minimum Data Set) assessment, dated 7/30/14, indicated Resident #79 had a BIMS (Brief Interview for Mental Status) score of 3, which indicated the resident had severe cognitive impairment.</p> <p>Resident #79 had a care plan, dated 8/2/14, which indicated nebulizers treatments were to be administered as ordered.</p> <p>Resident #79 had a physician's order, dated 7/23/14, for Duoneb inhalation solution, use 1 (one) vial through the nebulizer 3 (times) daily.</p> <p>A "Nebulizer Treatment Flow Sheet," indicated Resident #79 had an assessment completed prior to, during, and after the nebulizer treatments as followed: 7/24/14 for three treatments with no breath sounds documented after the nebulizer treatments 7/25/14 for one treatment at 1700 (5 p.m.) with no breath sounds documented after the treatment 7/28/14 for three treatments 7/30/14 for 1 treatment at 0600 (6 a.m) 8/1/14 for 1 treatment - no time</p> <p>The clinical record lacked further documentation for any assessments for the nebulizer treatments.</p>		<p>the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> ·All residents who reside in the facility and receive nebulizer treatments have the potential to be affected by the same alleged deficient practice. ·The facility nurses will be educated on nebulizer administration, assessments, and documentation on or before Jan 19th 2015 by the CEC or designee ·An audit will be performed DNS or designee on all residents who have orders for nebulizers ensuring they have the appropriate nebulizer flow sheet with an appropriate assessment documented. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·When a nurse administers a nebulizer treatment per the physician order the nurse will assess and document the residents pulse, respirations, breath sounds and sat prior to the treatment, assess and document the residents pulse, respirations, breath sounds and sat during the treatment, and assess and document the residents pulse, respirations, breath sounds and sat after the treatment on the nebulizer flow sheet. ·The facility nurses will be 				

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F000465 SS=E	<p>During an interview on 12/18/14 at 8:55 a.m., RN #1 indicated a resident was to have their breath sounds, pulse, respirations, and a pulse oximeter obtained before, during, and after receiving a nebulizer treatment and the assessment should be documented on the "Nebulizer Treatment Flow Sheet."</p> <p>A "Nebulizer Treatment Skill Validation checklist," dated 9/2012 and received from the AIT (Administrator in Training) on 12/18/14 at 9:58 a.m., indicated an assessment including pulse, respiration, breath sounds, and pulse oximetry, should be performed pre-, during, and post- administration of the nebulizer treatment. The form further indicated the information should be documented on the "Nebulizer Treatment Flow Sheet."</p> <p>3.1-47(a)(6)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p>	F000465	<p>educated on nebulizer administration, assessments, and documentation on or before Jan 19th 2015 by the CEC or designee</p> <ul style="list-style-type: none"> ·DNS or designee will audit the mar daily ensuring residents who receive nebulizer treatments have the appropriate assessments and documentation completed. 4: How the corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place ·A nebulizer CQI audit tool will be completed for six months with audits being completed once weekly for one month and monthly for 5 months by the DNS or designee. ·The nebulizer CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. ·Deficiency in this practice will result disciplinary action up to and including termination of the responsible employee. ·Date of Compliance 1/19/2015. <p>It is the practice of this provider to</p>	01/19/2015

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	<p>Based on observation, interview and record review, the facility failed to ensure a safe, comfortable, sanitary environment for 9 of 31 resident rooms reviewed, in that, walls were scuffed, painted chipped, floors had buildup and debris. (117, 206, 210, 211, 212, 214, 215, 218, 220)</p> <p>Findings include:</p> <p>On 11/20/14 during Stage 1 interview and observation the following rooms were observed.</p> <p>1) Room 117A had paint chipped and missing on wall on head of bed.</p> <p>2) Room 206 had chipped paint missing on bathroom walls.</p> <p>3) Room 210 had areas of chipped paint missing on bedroom wall.</p> <p>4) Room 210 and 212 had gray buildup around toilet, corners of bathroom had debris and gray buildup.</p> <p>5) Room 211 had a blackened area around base of commode in the bathroom.</p> <p>6) Room 214 the toilet is sitting sideways off the original base and away from</p>		<p>ensure that allalleged violations involving safe/functional/sanitary/comfortable environment arein accordance with State and Federal law. 1: What corrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice</p> <ul style="list-style-type: none"> ·The missing and chipped paint on the wall at the head of the bed in room 117a wasrepaired ·The chipped and missing paint on the bathroom walls of room 206 was repaired ·The chipped and missing areas of paint on the bedroom wall of room 210 was repaired ·The gray buildup around the toilet, the corners of the bathroom with debris and gray buildup were cleaned and repaired inrooms 210 and 212 ·The blackened area around the base of the commode in the bathroom of room 211 was cleaned and repaired ·The toilet in room 214 was repaired and reset in the appropriate position. ·The faucet handles in room 215 were replaced ·The personal items in room 218 and 220 were labeled and removed <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> ·All residents who reside in the 	

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	<p>grout, there is not leakage.</p> <p>7) Room 215 had faucet handles which were loose and rusty in the bathroom.</p> <p>8) Rooms 218 & 220 had toothbrushes, moisturizer, baby wipes, body soap on vanity in the bathroom unlabeled.</p> <p>On 12/22/14 at 2:41 p.m. an interview with Head Of Maintenance indicated he will check these rooms 214 for toilet sitting sideways, and 215 for loose rusty faucet handles.</p> <p>On 12/23/14 at 10:45 a.m. the Head of Housekeeping was interviewed in reference to the usual cleaning schedule. She indicated the room floors are deep cleaned every month. A policy was received from Head of Housekeeping indicating " the Cleaning Guidelines" in which deep cleaning of rooms are done on a monthly basis.</p> <p>On 12/23/14 at 10:50 a.m. a policy was received from Head of Maintenance titled "Weekly Tasks/Verify Proper Operations" which indicated on a weekly basis what areas are concentrated on for the month.</p> <p>On 12/23/14 at 11:02 a.m. the Administrator was interviewed regarding</p>		<p>facility havethe potential to be affected by the same alleged deficient practice.</p> <ul style="list-style-type: none"> ·The CEC or designee will educate all staff on reporting any non homelike environmental observations to the facility supervisorfor repair and or cleaning on before 1/19/2015. ·The CEC or designee will educate all staff on appropriate labeling and storage of personal items on or before 1/19/2015 ·The housekeeping supervisor or designee will educate facility housekeepers on proper cleaning techniques and schedules on orbefore 1/9/15 ·An audit of all rooms and hallways was conductedby the maintenance and housekeeping supervisors and repairs and needed cleaning have been scheduled to be completed to ensure the rooms present as a home like environment. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·The CEC or designee will educate all staff onreporting any non home like environmental observations to the facility supervisorfor repair and or cleaning on before 1/19/2015. ·The CEC or designee will educate all staff on appropriate labeling and storage of personal items on or before 1/19/2015 ·The housekeeping supervisor 	

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	<p>policy on labeling residents personal care items. She indicated that if residents are self care they probably know which one is theirs. She was not sure there was a policy, but she would look for one. No policy was recieved.</p> <p>3.1-19(f)</p>		<p>or designee will educate facility housekeepers on proper cleaning techniques and schedules on orbefore 1/19/15</p> <ul style="list-style-type: none"> ·The facility department heads will complete daily rounds Monday thru Friday and report any environmental findings in the afternoon CQI meeting. The weekend housesupervisor will make rounds on Saturday and Sunday and report abnormal findings to the executive director. These findings will be logged in the maintenance repair log and audited daily to ensure they are completed. ·The facility has created a maintenance repairand evaluation schedule. The maintenance director will evaluate facility areas on a scheduled basis ensuring they present as a homelike environment. Items identified that are in need of repair will be logged and scheduled for repair. ·The housekeeping supervisor will perform daily audits of resident rooms Monday through Friday to ensure appropriate cleaning of resident rooms and floors. Identified areas needed cleaning will be addressed immediatly by the housekeeping staff. The weekend supervisor will complete the audits on the weekends. ·The ED will oversee the maintenance schedule and housekeeping cleaning schedule to ensure rooms are cleaned and repaired as scheduled and 	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2015
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