

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155238	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2016
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NAME OF PROVIDER OR SUPPLIER YORKTOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S ANDREWS RD YORKTOWN, IN 47396
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 1, 2, 3, 4, 5, 2016</p> <p>Facility number: 000143 Provider number: 155238 AIM number: 100283890</p> <p>Census bed type: SNF/NF: 52 Total: 52</p> <p>Census payor type: Medicare: 8 Medicaid: 37 Other: 7 Total: 52</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on February 9, 2016.</p>	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on this survey report. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the</p>			

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

TITLE

(X6) DATE

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

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	<p>resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of a blood glucose level which could have resulted in the need to alter treatment for 1 of 2 residents reviewed for insulin sliding scale coverage. (Resident #62)</p>	F 0157	It is the practice of Yorktown Manor Health Care Center to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a blood glucose level which could have resulted in the need to alter treatment. I.	03/05/2016

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	<p>Findings include:</p> <p>The clinical record for Resident #62 was reviewed on 2/3/16. Diagnoses for Resident #62 included, but were not limited to, dementia, diabetes, and constipation.</p> <p>Current physician orders for Resident #62 included, but were not limited to, the following:</p> <p>a. Check and record blood glucose levels three times daily before meals due to diabetes. This order originated 6/2/15.</p> <p>b. Lantus (insulin) inject 15 units subcutaneously every night at bedtime. This order originated 11/19/15.</p> <p>c. Novolog (insulin) inject 5 units subcutaneously daily at 11:00 a.m. This order originated 11/19/15.</p> <p>d. Novolog (insulin) inject 5 units subcutaneously daily at 4:00 p.m. This order originated 11/19/15.</p> <p>e. Novolog (insulin) subcutaneously three times daily per sliding scale as follows for diabetes: 200 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units</p>		<p>Resident #62 clinical was reviewed for insulin sliding scale coverage. On 1/9/16 resident #62 blood glucose was 427 and, as survey findings indicate, coverage was provided. Resident #62 has had no further need to alter treatment. II. Ten Yorktown Manor Health Care Center residents who have blood glucose testing ordered have the potential to be affected. Yorktown Manor Health Care Center residents with blood glucose testing ordered have all been reviewed findings indicate all have parameters noted and no negative findings. III. Yorktown Manor Health Care Center has a policy regarding physician notification of resident changes. Nursing staff have been re-educated on the physician notification policy. IV. Yorktown Manor Health Care Center residents with blood glucose testing ordered have all been reviewed and findings indicate all have parameters noted and all with blood glucose readings within said parameters. The D.O.N, or designee, is conducting a quality assurance audit to ensure the residents blood glucose readings have a parameter ordered and if out of range the Physician is notified (attachment C). This QA audit will be completed 5 times per week for 4 weeks; then 3 times per week for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA</p>		

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	<p>351 - 400 = 8 units if less than 60 or greater than 450 call physician This order originated 5/8/15.</p> <p>Review of the January, 2016 Medication Administration Record (MAR) indicated Resident #62's blood glucose result on 1/9/16 at 4:00 p.m., was 427. The MAR indicated Resident #62 received 8 units of sliding scale insulin. The nurses notes on 1/9/16 lacked any documentation of the physician having been contacted for a blood glucose level not addressed by the insulin sliding scale order.</p> <p>During an interview on 2/5/16 at 11:00 a.m., RN #3 indicated the insulin sliding scale orders for Resident #62 had a gap in the coverage and did not make sense. RN #3 indicated a blood glucose level result for Resident #62 above 400 would have required notification of the physician for orders. RN #3 indicated the insulin sliding scale orders for Resident #63 needed clarification from the physician.</p> <p>During an interview on 2/5/16 at 11:10 a.m., the Assistant Director of Nursing (ADON) indicated the staff should have called the physician on 1/9/16 when Resident #62's blood glucose level was greater than 400.</p>		<p>committee monthly. any negative findings will add another 4 weeks of audits until 100% compliance is achieved.</p>	

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F 0309 SS=D Bldg. 00	<p>Review of the current, 4/2012 facility policy, titled "Change in a Resident's Condition or Status, provided by the ADON on 2/3/16 at 12:35 p.m., included, but was not limited to, the following:</p> <p>"...1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...</p> <p>...g. A need to alter the resident's medical treatment significantly;...."</p> <p>3.1-5(a)(3)</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 record review and interview, the facility failed to ensure the nursing staff assessed and monitored the dialysis dressing/catheter and/or dialysis access for 2 of 2 residents reviewed for dialysis services. (Resident #11 and #22)</p> <p>Findings include:</p>	F 0309	It is the practice of Yorktown Manor Health Care Center to provide the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care which includes	03/05/2016

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	<p>1. The clinical record for Resident #11 was reviewed on 2/4/16 at 7:27 a.m. Diagnosis for Resident #11 included, but were not limited to, end stage renal disease, diabetes, and congestive heart failure.</p> <p>Resident #11 had a current physician order, dated 1/8/16, for hemodialysis every Tuesday, Thursday, and Saturday.</p> <p>A current health care plan focus, initiated 1/12/16, indicated Resident #11 had end stage renal disease and required dialysis treatments. Interventions for this problem included, "Encourage resident to go for the scheduled dialysis appointments and Monitor labs [laboratory tests] and report to doctor as needed."</p> <p>A current health care plan focus, initiated 1/12/16, indicated Resident #11 was at risk for an infection related to the dialysis access on her chest and receiving an antibiotic at the dialysis unit. The intervention for this focus was to "notify the physician and the family as indicated."</p> <p>The nursing notes reviewed from 1/9/16 to 2/5/16 had 3 nursing note entries (1/10/16, 1/11/16, and 1/12/16) which</p>		<p>dialysis patient's dressing/catheter and/or dialysis access. I. Resident #11 and Resident #22 receive dialysis treatment. Their clinical records were reviewed and found to have vascular access devices for dialysis treatment without access device assessments. Resident #11 and Resident #22 have had assessments of their vascular access devices completed without negative findings. II. Two Yorktown Manor Health Care Center residents who have dialysis treatments with vascular access devices have the potential to be affected. Yorktown Manor Health Care Center residents with dialysis access devices have all been assessed without negative findings. III. Yorktown Manor Health Care Center has a policy regarding dialysis which includes access device assessments. Nursing staff have been re-educated on the dialysis policy. IV. Yorktown Manor Health Care Center residents with dialysis access devices have all been assessed without negative findings. The D.O.N, or designee, is conducting a quality assurance audit to ensure the residents dialysis access devices are accessed (attachment B1 and B2). This QA audit will be completed 3 time per week for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. Any negative</p>	

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	<p>documented an assessment of Resident #11's dialysis catheter/dressing.</p> <p>During an interview on 2/4/16 at 1:25 p.m., LPN #2 did not include an assessment of the dialysis catheter when she explained care and treatment for a dialysis resident. LPN #2 indicated there were 2 residents in the facility on dialysis. LPN #2 indicated Resident #11 had a dialysis catheter.</p> <p>During an interview on 2/5/16 at 11:00 a.m., RN #3 did not include an assessment of the dialysis catheter when she explained care and treatment for a dialysis resident. RN #3 indicated there were 2 residents in the facility on dialysis. RN #3 indicated Resident #11 had a dialysis catheter.</p> <p>During an interview on 2/5/16 at 11:10 a.m., the Assistant Director of Nursing (ADON) indicated dialysis catheter and/or dialysis access assessments were not being completed by the nursing staff. The ADON indicated there were 2 residents on dialysis in the facility. Resident #11 had a dialysis catheter and Resident #22 had a dialysis access in her arm.</p> <p>2. The clinical record for Resident #22 was reviewed on 2/5/16 at 1:02 p.m.</p>		findings will add another 4 weeks of audits until 100% compliance is achieved.				

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	<p>Diagnoses for Resident #22 included, but were not limited to, end stage renal disease, diabetes, and dementia.</p> <p>Resident #22 had a current signed physician order, for dialysis three times a week.</p> <p>A current health care plan focus, initiated 3/16/15, indicated Resident #22 had end stage renal disease and required dialysis treatments. Interventions for this focus included, but were not limited to, "notify physician and family of problems such as the absence of a bruit or thrill , observe the dialysis access site after return from dialysis treatment, and monitor the dialysis access site for bruit and thrill (the sound and feel of blood flow through the dialysis access)."</p> <p>Review of the January, 2016 and February, 2016, Medication Administration Records lacked any assessment of Resident #22's dialysis access.</p> <p>The January, 2016 nursing notes were reviewed with no entries related to the assessment of the Resident #22's dialysis access in her arm.</p> <p>During an interview on 2/4/16 at 1:25 p.m., the information LPN #2 provided</p>			

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	<p>related to the care of a dialysis resident did not include an assessment of the dialysis access in an arm. LPN #2 indicated there were 2 residents in the facility on dialysis. LPN #2 indicated Resident #22 had a dialysis access in her arm.</p> <p>During an interview on 2/5/16 at 11:00 a.m., the information RN #3 provided related to the care of dialysis resident did not include an assessment of the dialysis catheter and/or dialysis access in an arm. RN #3 indicated there were 2 residents in the facility on dialysis. RN #3 indicated Resident #22 had a dialysis access in her arm.</p> <p>During an interview on 2/5/16 at 11:10 a.m., the Assistant Director of Nursing (ADON) indicated Resident #22 came into the facility with the dialysis access already in place in her arm and the access was not being assessed by the nursing staff.</p> <p>Review of the current facility policy, which went into effect 09/2015, titled "End-Stage Renal Disease, Care of a Resident with", provided by the ADON on 2/5/16 at 1:25 p.m., included, but was not limited to, the following:</p> <p>"...Residents with end-stage renal disease</p>			

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F 0329 SS=D Bldg. 00	<p>[ESRD] will be cared for according to currently recognized standards of care....</p> <p>...1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents.</p> <p>2. Education and train of staff includes, specifically:</p> <p>a. The nature and clinical management of ESRD [including infection prevention and nutritional needs];</p> <p>b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis;...</p> <p>...g. The care of shunts and fistulas...</p> <p>...4. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care."</p> <p>Review of the website "http://dx.doi.org/10.1155/212/649735" on 11/12/14 indicated the following: "The International Journal of Nephrology 2012 (2012), article ID 649735, 9 pages...Monitoring and surveillance of vascular access are an integral part of the care of hemodialysis patient."</p> <p>3.1-37(a)</p>			
	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS			

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	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and 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 bowel interventions to prevent constipation were provided per facility policy for 2 of 5 residents reviewed for unnecessary medications. (Resident #'s 10 and #62)</p> <p>Findings include:</p> <p>1. Resident 10's clinical record was reviewed on 2/3/16 at 8:21 a.m. The resident's diagnoses included, but were not limited to, constipation, Parkinson's disease, history of nausea and vomiting and history of falls.</p>	F 0329	<p>It is the practice of Yorktown Manor Health Care Center to ensure each resident's drug regimen is free from unnecessary drugs, and further, to ensure bowel interventions to prevent constipation were provided per facility policy. I. Resident #10 and Resident #62 clinical records were reviewed and found to have medications ordered that have an adverse side effect of constipation. Resident #10 and Resident #62 have since had bowel motility promotion interventions and results as the survey findings indicate. II. All Yorktown Manor Health Care Center Residents who have</p>	03/05/2016

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	<p>The resident had current signed physician's orders for olanzapine 2.5 mg one tablet by mouth at bedtime for hallucinations, trazodone 100 mg one tablet at bedtime for insomnia, and duloxetine 60 mg one capsule everyday for depression. Each of these medications have an adverse side effect of constipation per the "2014 Nursing Drug Handbook."</p> <p>Review of Resident #10's bowel monitoring log indicated the resident had no bowel movement on January 11, 12, 13, 14, or 15, 2016. Review of the Medication Administration Record and Nurse Progress Notes lacked an indication of an intervention or an assessment of the resident's bowels during this five day period with no bowel movement.</p> <p>The bowel monitor log for January 17, 18, 19, 20 and 21, 2016 indicated the resident had no bowel movement. The resident had a 1/21/16 telephone order for Milk of Magnesium 30 ml by mouth every four hours as needed for constipation. The Medication Administration Record and Nurse Progress Notes lacked an indication of the Milk of Magnesium having been given at this time.</p>		<p>medications ordered that include an increased risk for side effects of constipation are at risk. Yorktown Manor Health Care Center Residents have all been assessed without negative findings. III. Yorktown Manor Health Care Center has a policy regarding bowel elimination which includes bowel elimination protocol. Nursing staff have been re-educated on the bowel elimination policy. IV. Yorktown Manor Health Care Center Residents have all been assessed without negative findings. The D.O.N, or her designee, is conducting a quality assurance audit to ensure the Residents have appropriate measures implemented relative to management of bowel function (attachment A). This QA audit will be completed 5 times per week for 4 weeks; then 3 times per week for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. Any negative findings will add another 4 weeks of audits until 100% compliance is achieved.</p>		

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	<p>Resident #10 had a 12/16/15 bowel and bladder assessment. The assessment indicated the resident was to be on a toileting schedule with the assistance of one.</p> <p>The resident had a 12/18/15 care plan focus for being at risk for decreased bowel motility. Interventions included, but were not limited to, "monitor bowel movements per policy and notify family and MD as indicated."</p> <p>During an interview with the Assistant Director of Nursing on 2/4/16 at 1:54 p.m., she indicated she could not find any indication the Milk of Magnesium was given following the 5 day period without documented bowel movements (1/17/16 through 1/21/16).</p> <p>2. The clinical record for Resident #62 was reviewed on 2/3/16. Diagnoses for Resident #62 included, but were not limited to, dementia, diabetes, and constipation.</p> <p>Resident #62 had a 11/26/15, 5 day Minimum Data Set (MDS) assessment which indicated the resident had severe cognitive impairment and never or rarely made decisions. The assessment indicated Resident #62 required extensive assist of two or more staff for</p>			

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	<p>toileting and was only able to stabilize moving off and on the toilet with human assist.</p> <p>Resident #62 had a current physician order for Milk of Magnesia (a laxative medication) 30 ml by mouth daily as needed for constipation. The order originated on 11/19/15.</p> <p>The clinical record for Resident #62 lacked a documented bowel movement on the following dates:</p> <p>11/22/15 - the response "None" was documented.</p> <p>11/23/15 - the response "None" or "Not Applicable" was documented.</p> <p>11/24/15 - the response "None" or "Not Applicable" was documented.</p> <p>11/25/15 - the response "None" or "Not Applicable" was documented.</p> <p>A total of 4 days without a documented bowel movement.</p> <p>12/29/15 - the response "None" or "Not Applicable" was documented.</p> <p>12/30/15 - the response "None" or "Not Applicable" was documented.</p> <p>12/31/15 - the response "None" or "Not Applicable" was documented.</p> <p>1/1/16 - the response "None" or "Not Applicable" was documented.</p> <p>A total of 4 days without a documented</p>			

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	<p>bowel movement.</p> <p>1/4/16 - the response "None" or "Not Applicable" was documented. 1/5/16 - the response "None" or "Not Applicable" was documented. 1/6/16 - the response "None" or "Not Applicable" was documented. 1/7/16 - the response "None" or "Not Applicable" was documented. A total of 4 days without a documented bowel movement.</p> <p>1/11/16 - the response "None" was documented. 1/12/16 - the response "None" or "Not Applicable" was documented. 1/13/16 - the response "None" or "Not Applicable" was documented. 1/14/16 - the response "None" or "Not Applicable" was documented. 1/15/16 - the response "None" or "Not Applicable" was documented. A total of 5 days without a documented bowel movement.</p> <p>The nursing notes lacked any information related to any assessments, notification of the physician, interventions having been given or tried during these time periods. Review of the November, 2015 and December, 2015 Medication Administration Records (MAR) indicated no "as needed" medication for</p>			

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	<p>constipation had been given to Resident #62. The January, 2016 MAR indicated Resident #62 had been given Milk of Magnesia on 1/13/16. The clinical record lacked any documented results.</p> <p>During an interview on 2/5/16 at 11:00 a.m., RN #3 indicated a daily report was generated for the nurses on the residents without a documented bowel movement for the past 3 days. RN #3 indicated each shift was to review this information. RN #3 indicated if a resident had not had a documented bowel movement in 3 days the nurse would give the physician ordered medication, assess the resident and document the information in the nurses notes.</p> <p>During an interview on 2/5/16 at 11:10 a.m., the Assistant Director of Nursing (ADON) indicated she did not know why the bowel monitoring was not completed or the "as needed" medications for constipation not given for Resident #62.</p> <p>The 1/2016, "Effective Bowel Elimination Policy and Procedure" was provided by the Assistant Director of Nursing on 2/4/16 at 1:46 p.m. The policy indicated the following: "Policy Statement It is the intent of the facility nursing personnel to document, monitor and implement appropriate measures</p>			

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F 0387	<p>relative to management of bowel function. The bowel regimen will be initiated by the Licensed Nurse with the approval from the attending Physician as indicated....2. When a problem e.g., constipation or diarrhea is identified, orders for intervention will be determined by the physician. 3. Certified Nursing Assistant will document the resident bowel movement daily in the resident's record. 4. If a resident self-toilets the Certified Nursing Assistant will inquire prior to the end of their shift if the resident has a bowel movement and record results in the resident's record. 5. Documentation should reflect approximate size (i.e. small medium large extra-large.) The number of bowel movements should also be noted...7. The Nurse will review the residents ADL [activities of daily living] documentation in regard to bowel movements. If a resident has no bowel movement by the third day, the Nurse will notify the physician and follow ordered protocol. 8. The charge nurse will document the intervention ordered. 9. The Nurse will communicate with the physician if bowel irregularity persists."</p> <p>3.1-48(a)(3)</p> <p>483.40(c)(1)-(2)</p>			

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SS=D Bldg. 00	<p>FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility failed to ensure a resident was seen by the physician timely for the 30 day visit after admission for 1 of 5 residents reviewed for unnecessary medications. (Resident #10)</p> <p>Findings include:</p> <p>Resident #10's clinical record was reviewed on 2/3/16 at 8:21 a.m. The resident was admitted to the facility on 12/15/15. The resident's diagnoses included, but were not limited to, hallucinations, Parkinson's disease, history of nausea and vomiting and history of falls.</p> <p>The resident's physician orders were signed on 12/15/15. The resident had a Nurse Practitioner Note dated 2/2/16. This was 49 days without a physician visit.</p> <p>Review of the Nurse Progress Notes indicated the resident had a change in</p>	F 0387	<p>It is the practice of Yorktown Manor Health Care Center to ensure each Resident is seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter, noting further, that a physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>I. Resident #10 clinical records were reviewed and found to have a physician visit 49 days after admission. Since the surveyor findings Resident #10 is within compliance of physician visits with no negative findings.</p> <p>II. All Yorktown Manor Health Care Center Residents who were admitted to the facility are at risk. All Yorktown Manor Health Care Center Residents records have all been assessed for physician visits without negative findings.</p> <p>III. Yorktown Manor Health Care Center has a policy regarding physician visits. Nursing staff have been re-educated on the physician visits policy.</p>	03/05/2016

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	<p>condition which may have needed an assessment by the physician during the following entries:</p> <p>12/25/15, 2:00 a.m., The resident was placed on an antibiotic for an elevated temperature and heart rate.</p> <p>12/26/15, 6:48 a.m., New order to discontinue Keflex and start doxycycline [an antibiotic] 100 mg by mouth two times a day for ten days.</p> <p>1/14/16, 11:28 a.m., The resident had fallen in her room and had a small raised area on her head.</p> <p>An antibiotic review, dated 12/28/15, indicated the following: doxycycline 100 mg one tablet by mouth two times a day for 10 days. Urinary/clinical evidence: temperature; new/increased lethargy/Confusion. Onset 12/25/15 T [temperature] 100.3.</p> <p>Review of Resident #10's bowel monitoring log indicated the resident had no bowel movement on January 11, 12, 13, 14, or 15, 2016. The bowel monitor log for January 17, 18, 19, 20 and 21, 2016 indicated the resident had no bowel movement.</p> <p>During an interview with the Assistant</p>		<p>IV. Yorktown Manor Health Care Center Residents records have all been assessed for physician visits without negative findings. The DON, or her designee, is conducting a quality assurance audit to ensure the Residents have been seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter noting that a physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This QA audit will be completed 1 times per week for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. Any negative findings will add another four weeks of audits until 100% compliance is achieved.</p>	

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F 0465 SS=E Bldg. 00	<p>Director of Nursing on 2/3/16 at 10:08 a.m., she indicated the Nurse Practitioner had seen the resident on 2/2/16, but did not sign the physician orders. She indicated the resident had not been seen by the physician since admission.</p> <p>The 9/2013, revised "Physician Visits" policy was provided by the Assistant Director of Nursing on 2/3/16 at 3:24 p.m. The policy indicated the following: "...Each resident shall be assessed by a physician no less frequently that as prescribed by current regulatory statutes. Policy Interpretation and Implementation</p> <p>1. Residents must be seen by a physician once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. 2. Physician visits are considered timely if they occur no later than 10 days after the required date...7. During each visit, the physician must sign and date progress notes and orders...."</p> <p>3.1-22(d)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p>			

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	<p>Based on observation, record review and interview, the facility failed to ensure resident rooms were clean, in good repair and odor free for 10 of 30 rooms observed for a clean homelike environment. This deficient practice had the potential to affect 20 residents who could reside in the 20 licensed beds. (Resident Rooms 104, 202, 203, 205, 207, 208, 211, 212, 301, and 304)</p> <p>Findings include:</p> <p>1. The following observations of resident rooms were made during the following dates and times;</p> <p>Room 104 on 2/1/16 at 11:19 a.m., the wall next to the wall mounted television had four un-patched holes, the cove base was discolored and pulling away from the wall. There were black scuff marks on the lower portion of the bathroom door. The bathroom floor had a dark area around the base of the stool.</p> <p>Room 202 on 2/1/16 at 11:02 a.m., the corners at the entrance of the room had dirt build up approximately the size of a saucer expanding out from the wall.</p> <p>Room 203 on 2/1/16 at 11:12 a.m., there were black scuff marks approximately the size of a dinner plate on the wall behind</p>	F 0465	<p>It is the practice of Yorktown Manor Health Care Center to provide a safe functional, sanitary, and comfortable environment for residents, staff and the public. I. Resident rooms 104, 202, 203, 205, 207, 208, 211, 212, 301, and 304 were observed to have several environmental concerns. Above stated rooms have been deep cleaned and all concerns noted have been corrected. II. All resident rooms at Yorktown Manor Health Care Center have the potential to be affected. Yorktown Manor Health Care Center resident rooms have been assessed without negative findings. III. Yorktown Manor Health Care Center has a policy regarding preventative maintenance of resident rooms and proper cleaning of resident rooms. Housekeeping staff and Maintenance Personnel have been re-educated in regards to preventative maintenance and proper cleaning of resident rooms. IV. Yorktown Manor Health Care Center resident rooms have all been assessed with no further negative findings. The Maintenance Director, or designee is conducting preventative maintenance rounds on all resident rooms (attachment D). The Housekeeping Supervisor, or designee will complete rounds on all resident rooms to ensure proper cleaning (attachment E). These QA audits</p>	03/05/2016			

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	<p>the bed next to the window. The corners at the entrance of the room had dirt build up approximately the size of a baseball expanding out from the wall. The corner outside the bathroom door had black scuff marks approximately 12 inches up from floor covering the wall.</p> <p>Room 205 on 2/1/16 at 12:25 p.m., the corner's at the entrance of the room had dirt build up approximately the size of a saucer expanding out from the wall. There were black scuff marks on the lower portion of the bathroom door.</p> <p>Room 207 on 2/2/16 at 9:07 a.m., the cove base which was approximately 3 feet in length was missing on the wall adjacent to the window extending from corner to a dresser. The corner's at the entrance to bathroom and entry door had dirt build up approximately the size of a quarter expanding out from wall at the bathroom entrance and approximately the size of a baseball at the entry door.</p> <p>Room 208 on 2/2/16 at 10:18 a.m., the corners at the entrance of the room had dirt build up approximately the size of a saucer expanding out from the wall.</p> <p>Room 211 on 2/2/16 at 9:27 a.m., the bathroom wall had paint scuffed. The floor at the base of the toilet was cracked.</p>		will be completed 3 times per week for 4 weeks; then weekly for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. any negative findings will add another 4 weeks of audits until 100% compliance is achieved.	

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	<p>The cove base on the wall in front of the toilet was discolored. The bathroom door jambs were gouged at the bottom of the door. The corners at the entrance of the room had dirt build up approximately the size of a baseball expanding out from the wall.</p> <p>Room 212 on 2/2/16 at 10:14 a.m., the closet doors had no handles or knobs. The corner of room had a black substance on floor. The cove base had dark areas. The bathroom floor had a dark area around the base of the stool and a build up of dirt in the corners.</p> <p>Room 301 on 2/1/16 at 10:59 a.m., the bathroom had un-patched holes on the wall, black scuff marks on the lower part of the bathroom door, and the floor at the base of the stool was discolored. The dresser in the room had the finish worn off in areas. A picture on the wall was missing a section of the frame at the corner.</p> <p>Room 304 on 2/2/16 at 10:42 a.m., the closet door had missing paint. The dresser in the room had the finish worn off in areas. The cove base in the corner beside the closet was pulling away from the wall. The bathroom floor had a dark area around the base of the stool. A build up of dirt in the corners. The bathroom</p>			

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	<p>floor was sticky.</p> <p>Room 403 on 2/2/16 at 11:46 a.m., the closet doors did not shut completely when closed, and the finish was missing in areas. Resident #12's husband was in the room and indicated the closet doors appeared to be warped. The corners were missing paint, and had scuffed marks. The bathroom door was missing the paint at the bottom of the door and had large gouged areas on the bottom of the bathroom door.</p> <p>Room 406 on 2/2/16 at 9:23 a.m., the bathroom walls and doorframe were scuffed and missing paint.</p> <p>Room 407 on 2/1/16 at 2:46 p.m., the bathroom had soiled towels on the floor. The bathroom floor was sticky. The floor at the base of the toilet had a brown discoloration around the toilet. There was a large unpainted area on the bathroom wall located at the height of the bathroom door knob.</p> <p>2. During the initial tour on 2/1/16 at 9:30 a.m., the following was observed:</p> <p>The wallpaper under the hand rails next to the 300 hall shower room had black scuff marks.</p>			

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	<p>The wallpaper under the hand rails around the phone on the 400 hall had brown water spots approximately the size of saucer.</p> <p>The light cover on the ceiling light in front of the nurses station was broken and missing a section approximately the size of a baseball.</p> <p>The light cover on the ceiling light in front of room 108 was broken.</p> <p>The carpet was worn in front of room 209.</p> <p>The wallpaper was peeling from the wall by the phone at the end of the 200 hall.</p> <p>3. The environmental tour was conducted on 2/4/16 from 9:45 a.m. to 10:32 a.m., with the Maintenance Supervisor, the Administrator, and the Housekeeping Supervisor present. The areas of concern in both resident rooms and common areas were brought to the attention of the Administrative Staff.</p> <p>During record review on 2/4/16 at 3:26 p.m., the "MONTHLY MAINTENANCE RESIDENT ROOM CHECKLIST" was completed for the following room's 104, 202, 203, 205, 207, 208, 211, 212, 301, 304 with no concerns noted. The</p>			

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	<p>"MONTHLY MAINTENANCE RESIDENT ROOM CHECKLIST" was not completed for the 400 hall in the month of January, and the February log forms had not been initiated.</p> <p>During an interview on 2/4/16 at 3:13 p.m., the Housekeeping Supervisor indicated that the daily cleaning procedure was the same as the weekly deep clean procedure.</p> <p>During an interview on 2/5/16 at 8:36 a.m., the Maintenance Supervisor indicated that the building had been approved for the scheduled remodeling. He provided a project plan of the removal of wallpaper and painting in the main entrance area, 100 hall area, and 100 hall residents room to be completed by him with a completion date of 3/31/16. The completion date for the 200 hall and 200 hall residents room was 6/30/16. The completion date for the 300 hall and the 300 hall resident rooms was 9/30/16. The completion date for the 400 hall and the 400 hall resident rooms was 12/31/16. He also indicated he had been making small repairs as time permitted.</p> <p>The undated, "Housekeeping Procedure" provided by the Housekeeping Supervisor on 2/4/16 at 3:16 p.m., indicated... "monthly deep clean of every</p>			

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	<p>residents room (1-2 rooms a day) consists of but not limited to: pull out all furniture from residents room. Wipe down walls, Privacy curtains checked. Sweep and mop floors. Wipe down blinds. Disinfect tables, table legs, bed frame, sink and toilet with disinfect. Weekly deep clean of every resident's room consists of but not limited to: dusting furniture, picture frames, TV screens. Cleaning toilets and sinks. Sweeping and mopping residents floors, privacy curtains checked...."</p> <p>The "Deep Cleaning Schedule" for the months of January, 2016 and February, 2016 was provided by the Housekeeping Supervisor on 2/4/16 at 3:16 p.m. The schedule indicated rooms 104, 202, 203, 205, 207, 208, 211, 212, 301, and 304 were deep cleaned in the month of January, and room 104 had been deep cleaned on 2/3/16.</p> <p>The 2/1/16, "Bed Inventory" form, completed by the Maintenance Supervisor, indicated the following: Rooms 104, 204, 203, 205, 207, 208, 211, 212, 301, and 304 were each licensed for 2 beds. Resulting in the possibility of 20 resident residing in the rooms with identified concerns.</p> <p>3.1-19(f)</p>			

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F 0520 SS=E Bldg. 00	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility's QAA (Quality Assessment and Assurance) Committee failed to identify and implement a plan of action to address environmental cleanliness for hallways 100, 200, 300, and 400. This deficient practice had the potential to impact 20 residents. (Rooms 104, 202, 203, 205, 207, 208, 211, 212, 301, 304, 403, 406, and 407)</p>	F 0520	It is the practice of Yorktown Manor Health Care Center Quality Assessment and Assurance Committee to attempt to identify, develop and implement appropriate plans of action to identified quality deficiencies. I. Resident rooms 104, 202, 203, 205, 207, 208, 211, 212, 301, and 304, 403, 406, and 407 were observed to have several environmental concerns that were not identified to the QA	03/05/2016

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	<p>Findings include</p> <p>1. The following observations of resident rooms were made during the following dates and times;</p> <p>Room 104 on 2/1/16 at 11:19 a.m., the wall next to the wall mounted television had four un-patched holes, the cove base was discolored and pulling away from the wall. There were black scuff marks on the lower portion of the bathroom door. The bathroom floor had a dark area around the base of the stool.</p> <p>Room 202 on 2/1/16 at 11:02 a.m., the corner's at the entrance of the room had dirt build up approximately the size of a saucer expanding out from the wall.</p> <p>Room 203 on 2/1/16 at 11:12 a.m., there were black scuff marks approximately the size of a dinner plate on the wall behind the bed next to the window. The corner's at the entrance of the room had dirt build up approximately the size of a baseball expanding out from the wall. The corner outside the bathroom door had black scuff marks approximately 12 inches up from floor covering the wall.</p> <p>Room 205 on 2/1/16 at 12:25 p.m., the corner's at the entrance of the room had dirt build up approximately the size of a</p>		<p>Committee. Above stated rooms have been deep cleaned and all concerns noted have been corrected and plans of action have been identified to the QA Committee . II. All resident rooms at Yorktown Manor Health Care Center have the potential to be affected. Yorktown Manor Health Care Center resident rooms have been assessed without negative findings. III. Yorktown Manor Health Care Center has a policy regarding preventative maintenance of resident rooms and proper cleaning of resident rooms and Quality Assessment and Assurance Committee obligations. Housekeeping staff and Maintenance Personnel have been re-educated in regards to preventative maintenance and proper cleaning of resident rooms. All staff, including new Administrator have been educated and re-educated in regards to QA responsibilities. IV. Yorktown Manor Health Care Center resident rooms have all been assessed with no further negative findings. The Maintenance Director, or designee is conducting preventative maintenance rounds on all resident rooms (attachment D). The Housekeeping Supervisor, or designee will complete rounds on all resident rooms to ensure proper cleaning (attachment E). Administrator, or designee will complete facility</p>		

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	<p>saucer expanding out from the wall. There were black scuff marks on the lower portion of the bathroom door.</p> <p>Room 207 on 2/2/16 at 9:07 a.m., the cove base which was approximately 3 feet in length was missing on the wall adjacent to window extending from corner to dresser. The corner's at the entrance to bathroom and entry door had dirt build up approximately the size of a quarter expanding out from wall at the bathroom entrance and approximately the size of a baseball at the entry door.</p> <p>Room 208 on 2/2/16 at 10:18 a.m., the corner's at the entrance of the room had dirt build up approximately the size of a saucer expanding out from the wall.</p> <p>Room 211 on 2/2/16 at 9:27 a.m., the bathroom wall had paint scuffed. The floor at the base of the toilet was cracked. The cove base on the wall in front of the toilet was discolored. The bathroom door jambs was gouged at the bottom of the door. The corner's at the entrance of the room had dirt build up approximately the size of a baseball expanding out from the wall.</p> <p>Room 212 on 2/2/16 at 10:14 a.m., the closet doors had no handles or knobs. The corner of room had a black substance</p>		<p>inspections rounds (attachment F) to ensure all potential and identified concerns have been brought to the QA Committee and a plan of action for identified concerns has been implemented. These QA audits will be completed 3 times per week for 4 weeks; then weekly for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. any negative findings will add another 4 weeks of audits until 100% compliance is achieved.</p>	

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	<p>on floor. The cove base had dark areas. The bathroom floor had a dark area around the base of the stool and a build up of dirt in the corners.</p> <p>Room 301 on 2/1/16 at 10:59 a.m., the bathroom had un-patched holes on the wall, black scuff marks on the lower part of the bathroom door, and the floor at the base of the stool was discolored. The dresser in the room had the finish worn off in areas. A picture on the wall was missing a section of the frame at the corner.</p> <p>Room 304 on 2/2/16 at 10:42 a.m., the closet door had missing paint. The dresser in the room had the finish worn off in areas. The cove base in the corner beside the closet was pulling away from the wall. The bathroom floor had a dark area around the base of the stool. A build up of dirt in the corners. The bathroom floor was sticky when walking upon.</p> <p>Room 403 on 2/2/16 at 11:46 a.m., the closet doors did not shut completely when closed, and the finish was missing in areas. Resident #12's husband was in the room and indicated the closet doors appeared to be warped. The corners were missing paint, and had scuffed marks. The bathroom door was missing the paint at the bottom of the door and had large</p>			

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	<p>gouged areas on the bottom of the bathroom door.</p> <p>Room 406 on 2/2/16 at 9:23 a.m., the bathroom walls and doorframe were scuffed and missing paint.</p> <p>Room 407 on 2/1/16 at 2:46 p.m., the bathroom had soiled towels on the floor. The bathroom floor was sticky when walked on. The floor at the base of the toilet had a brown discoloration around the toilet. There was a large unpainted area on the bathroom wall located at the height of the bathroom door knob.</p> <p>2. During the initial tour on 2/1/16 at 9:30 a.m., the following was observed:</p> <p>The wallpaper under the hand rails next to the 300 hall shower room had black scuff marks.</p> <p>The wallpaper under the hand rails around the phone on the 400 hall had brown water spots approximately the size of saucer.</p> <p>The light cover on the ceiling light in front of the nurses station was broken and missing a section approximately the size of a baseball.</p> <p>The light cover on the ceiling light in</p>			

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	<p>front of room 108 was broken.</p> <p>The carpet was worn in front of room 209.</p> <p>The wallpaper was peeling from the wall by the phone at the end of the 200 hall.</p> <p>3. The environmental tour was conducted on 2/4/16 from 9:45 a.m. to 10:32 a.m., with the Maintenance Supervisor, the Administrator, and the Housekeeping Supervisor present. The areas of concern in both resident rooms and common areas were brought to the attention of the Administrative Staff.</p> <p>The 2/1/16, "Bed Inventory" form, completed by the Maintenance Supervisor, indicated the following: Rooms 104, 204, 203, 205, 207, 208, 211, 212, 301, and 304 were each licensed for 2 beds. Resulting in the possibility of 20 resident residing in the rooms with identified concerns.</p> <p>4. During an interview on 2/5/16 at 1:09 p.m., the Administrator indicated no environmental concerns had been brought to the QAA committee during her 4 week interim as administrator, either by staff or at the corporate level. During an interview on 2/5/16 at 2:57 p.m., the Director of Nursing (DON) indicated no</p>			

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	<p>environmental concerns had been brought to the QAA committee. The DON indicated when the facility changed ownership a regional representative did an environmental tour of the facility.</p> <p>Environmental cleanliness and repair concerns were cited on the annual 12/19/14 survey.</p> <p>3.1-52(b)(2)</p>			