

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
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NAME OF PROVIDER OR SUPPLIER WESLEY MANOR HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 N MAIN ST FRANKFORT, IN 46041
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 7, 8, 9, 10, 11, 14, and 15, 2014</p> <p>Facility number: 001152 Provider number: 155658 AIM number: 200221050</p> <p>Survey team: Bobette Messman, RN, TC Rita Mullen, RN Maria Pantaleo, RN Holly Duckworth, RN</p> <p>Census bed type: SNF/NF: 86 Residential: 114 Total: 200</p> <p>Census/Payor type: Medicare: 9 Medicaid: 45 Other: 146 Total: 200</p> <p>Residential sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>R000</p> <p>Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor, Inc. provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents.</p> <p>As required, the facility submits the following plan of correction:</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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F000248 SS=D	<p>Quality Review was completed by Tammy Alley RN on July 21, 2014.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure the activities care plan for a resident was followed. This deficient practice effected 1 of 1 resident reviewed for activities. (Resident # 36).</p> <p>Findings include:</p> <p>The Clinical Record of Resident #36 was reviewed on 7/8/14 at 10:00 a.m. Diagnoses included but were not limited to, gait disturbance, bilateral lower extremity weakness and edema, chronic A-Fib, dementia, and hypertension.</p> <p>The Interdisciplinary Care Plan, dated 3/5/14, revised 6/4/14, indicated Resident #36 was to participate in group activities daily. Interventions included but were not limited to assistance to Sensory Club 4-5 times a week, offer conversation and</p>	F000248	<p>F248 This tag was cited due to the facility not being able to certify that the plan of care for one resident was not followed for specific activity programming. The facility will correct this problem for resident #36 by:</p> <ol style="list-style-type: none"> 1. Re-assessment of her activity-related needs. (Attachment A) 2. Revising her plan of care to meet all activity needs. (Attachment B) 3. Educating her assigned activity staff regarding the implementation of her plan of care 4. Assuring that her activity program participation is appropriately documented. We will identify any other residents who may potentially have been impacted by this problem by auditing the records of all residents who are involved in activities less than one-third of their available time. The audit (Attachment C) will 	08/14/2014

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	<p>allow resident time to reply.</p> <p>A review of July activities documentation indicated Resident #36 participated in group activity 6 out of 10 days. June activities documentation indicated Resident #36 participated in 17 out of 30 days. May activities indicated the resident participated in 6 out of 31 days.</p> <p>On 7/7/14 at 1:30 p.m., Resident #36 was observed in her room in bed, and asleep.</p> <p>On 7/8/14 at 10:00 a.m., Resident #36 was observed in her room, in her chair alone.</p> <p>On 7/9/14 at 9:00 a.m., Resident #36 was observed in the lounge in her chair, the activity was exercise, the residents' chair was turned away from the activity group and she did not participate.</p> <p>During an interview with Nurse #2 on 7/10/14 at 1:54 p.m., she indicated the activity calendar is specific to her floor, and few residents participate in activities. She indicated there was limited involvement for several months. Residents are usually in chairs in front of the TV.</p> <p>During an interview with the Activities Director on 7/11/14 at 10:26 a.m., she</p>		<p>seek to identify any residents who require and individualized plan of care to increase their activity participation and determine whether:</p> <ol style="list-style-type: none"> 1. Specific interventions to improve participation have been identified. 2. Implementation of the interventions is documented in the medical record or other appropriate facility record. <p>All Activity Assistants will be provided with in-service education that reminds them of the facility's policies for implementing and documenting care plan interventions, strategies for increasing resident involvement, and engaging residents with multiple levels of ability. The policy for Activity programs has been revised. (Attachment D) In order to monitor the effectiveness of this plan of correction, and in order to make certain that this problem does not arise in the future, the Activities Director will perform quality assurance audits (Attachment C) monthly for the next 90 days, and quarterly thereafter for a period of one year. All corrections for this tag will be completed by August 14th, 2014.</p>		

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F000272 SS=D	<p>indicated the staff do an activity interest assessment for the resident on admission. The activity director does all documentation for ground and first floor. Files are updated in resource meeting every day. Careplans are reviewed and revised on Tuesday afternoon, any issues that are important to the resident are communicated, and the care plan changed to reflect those issues. An activity participation book is maintained by the floor staff, all activity is documented in the activity participation book. The Activity Department identified this floor has concerns with activities.</p> <p>3.1-33(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;</p>			

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	<p>Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to correctly identify residents status regarding Hospice and Preadmission Screening and Resident Review (PASRR) for 2 of 2 residents reviewed for hospice and 1 of 1 residents reviewed for PASRR (Resident #68, 69 and 70).</p> <p>Findings include.</p> <p>1. The clinical record of Resident #68 was reviewed on 7/10/14 at 1:00 p.m. Diagnoses included, but were not limited to, dementia and fractured left hip.</p> <p>A Physician's order dated 5/6/14, indicated "May have [name of hospice] eval [evaluate] & tx [treat]."</p>	F000272	F272 This tag was cited due to MDS's for 3 residents notreflecting their status regarding hospice and PASRR. This tag will be corrected for these residents by: 1.The MDS for resident #70 will be corrected to indicate the PASRR Level II. 2.Resident #69 has passed away. 3.Resident #68's MDS will be corrected to reflect the certification of terminal illness (prognosis of less than 6 months to live). Other residents potentially impacted will be identifiedthrough an audit of all residents who are identified as a "level 2" and/or arereserved by hospice. The audit (AttachmentF) will determine whether the MDS correctly reflects their status as identifiedin the medical record. This audit	08/14/2014			

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	<p>A Physician's order, dated 5/8/14, indicated "May be followed by [name of hospice] for dementia with behaviors."</p> <p>A Nursing note, dated 5/9/14 at 2:00 p.m., indicated, "Res [resident] adm [admitted] to Hospice...."</p> <p>A Hospice admission note, dated 5/9/14 at 9:30 a.m., indicated Resident #68 was on hospice with a diagnosis of end stage dementia with behaviors.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 5/21/14, indicated Resident #68 was on Hospice and did not have a prognosis of less than six months.</p> <p>2. The clinical record of Resident #69 was reviewed on 7/9/14 at 2:45 p.m. Diagnoses included, but were not limited to, anemia, high blood pressure, vertigo, pneumonia and B-cell lymphoblastic leukemia. Resident #69 was admitted to the facility on 5/4/14.</p> <p>A Hospital History & Physical, dated 5/2/14, indicated, "... patient will go to a nursing home with skilled care vs hospice. No treatment with Rituximab, family agreeing to comfort measures only.</p>		<p>willbe repeated quarterly for one year. The MDS Coordinator will be informed of all residentsadmitted to hospice and all residents who are identified as a level 2. Upon receiving this information, the MDSCoordinator will audit the medical record to determine if the appropriatedocumentation is present. The facility has educated nurses to make certain thathospice certifications of terminal illness (CTI) are located in the front ofthe medical record in a protected sleeve and that the CTI is to be presented tothe facility prior to hospice providing services to any resident. The facility's policy for "supplemental care"providers has been revised. (AttachmentG) All corrections for this tag will be completed by August 14th,2014.</p>				

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	<p>A Hospital discharge order, dated 5/4/14, indicated the nursing home was to follow up with (name of hospice) for end of life care.</p> <p>A Hospice Admission note, dated 5/4/14 at 5:45 p.m., indicated Resident #69 was admitted to hospice with a diagnosis of acute B-cell lymphoblastic leukemia.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 5/14/14, indicated Resident #69 was on Hospice and did not have a prognosis of less than six months.</p> <p>During an Interview with the Director of Nursing and the MDS coordinator, on 7/10/14 at 10:30 a.m., regarding the terminal status of Residents #68 and 69. The MDS coordinator indicated, "Hospice would not send the resident's information to me to clarify the resident's terminal diagnosis. I was told I'd have to wait 90 days."</p> <p>3. Resident #70 was admitted to the facility on 07/02/10</p> <p>Record Review for Resident #70 was completed on 7/09/14 at 1:04 p.m. Diagnoses included but were not limited to, chronic dementia with behaviors, encephalomalacia, and mild mental retardation.</p>				

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	<p>An Annual Minimum Data Set (MDS) Assessment, completed 11/12/13, indicated Resident #70 had not been evaluated by level II Preadmission Screening and Resident Review (PASRR) and determined to have a serious mental illness and/or mental retardation or a related condition.</p> <p>A Quarterly MDS, completed 02/12/14, and Quarterly MDS, completed 05/15/14, did not indicate Resident #70 had a PASRR .</p> <p>PASRR form, signed by Division of Disability and Rehabilitation Services (DDRS) PASRR representative on 11/26/13, indicated Resident #70 had a developmental disability, met PASRR Level II criteria for continued residence in a nursing facility and needed nursing services for medical needs, geriatric medical issues, and resident alternative.</p> <p>During an interview with the MDS coordinator on 7/10/14 at 10:51 a.m., she indicated the MDS should have indicated Resident #70 had been evaluated by level II PASRR.</p> <p>3.1-31(a)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the 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 record review and interview, the facility failed to develop an individualized Care Plan which included Hospice care and services for 1 of 2 residents reviewed for Hospice Services (Resident #69)</p> <p>Findings include:</p> <p>The clinical record of Resident #69 was reviewed on 7/9/14 at 2:45 p.m.</p> <p>Diagnoses included, but were not limited</p>	F000279	F279 This tag was cited due to hospice services not being represented in the facility's plan of care, although she did have a separate plan of care for hospice. The resident whose plan of care was cited has since passed away. The facility will attempt to identify any other residents potentially impacted by auditing the medical records for all residents served by hospice. The audit (Attachment F) will seek to identify whether the responsibilities of the hospice	08/14/2014

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F000282 SS=D	<p>to, anemia, high blood pressure, vertigo, pneumonia and B-cell lymphoblastic leukemia. Resident #69 was admitted to the facility on 5/4/14.</p> <p>A Hospice Admission note, dated 5/4/14 at 5:45 p.m., indicated Resident #69 was admitted to Hospice on 5 /4/14.</p> <p>A review of Resident #69's facility Care Plans, dated 5/4/14, 5/6/14 and 5/7/14, did not indicate the resident was receiving hospice services and therefore what services were supported by hospice.</p> <p>During an interview with the Director of Nursing, on 5/10/14 at 10:30 a.m., she indicated hospice was not included on the facility care plans for Resident #69.</p> <p>3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure</p>	F000282	<p>provider are outlined in the facility's plan of care for hospice residents. This audit will be performed by the Director of Nursing on new hospice residents monthly for 90 days and then quarterly for one year. The facility has educated the hospice provider regarding the need to coordinate the plan of care with the facility's staff. The facility has revised its policy for supplemental care providers to include the need for a coordinated plan of care. (Attachment G) All corrections for this tag will be completed by August 14th, 2014.</p> <p>F282 This tag was cited due to the facility not being able to certify that the plan of care for one</p>	08/14/2014			

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	<p>the activities care plan for a resident was followed. This deficient practice effected 1 of 35 residents reviewed for activities. (Resident # 36).</p> <p>Findings include:</p> <p>The Clinical Record of Resident #36 was reviewed on 7/8/14 at 10:00 a.m. Diagnoses included but were not limited to, gait disturbance, bilateral lower extremity weakness and edema, chronic A-Fib, dementia,and hypertension.</p> <p>The Interdisciplinary Care Plan, dated 3/5/14, revised 6/4/14, indicated Resident #36 was to participate in group activities daily. Interventions included but were not limited to assistance to Sensory Club 4-5 times a week, offer conversation and allow resident time to reply.</p> <p>A review of July activities documentation indicated Resident #36 participated in group activity 6 out of 10 days. June activities documentation indicated Resident #36 participated in 17 out of 30 days. May activities indicated the resident participated in 6 out of 31 days.</p> <p>On 7/7/14 at 1:30 p.m., Resident #36 was observed in her room in bed, and asleep.</p>		<p>resident was not followed for specificactivity programming. The facility will correct this problem for resident #36 by:</p> <ol style="list-style-type: none"> 1.Re-assessment of her activity-related needs. (Attachment A) 2.Revising her plan of care to meet all activity needs. (Attachment B) 3.Educating her assigned activity staff regarding the implementation of her plan of care 4.Assuring that her activity program participation is appropriately documented. We will identify any other residents who may potentiallyhave been impacted by this problem by auditing the records of all residents whoare involved in activities less than one-third of their available time. The audit (Attachment C) will seek toidentify any residents who require and individualized plan of care to increasetheir activity participation and determine whether: <ol style="list-style-type: none"> 1. Specific interventions to improve participation have been identified. 2.Implementation of the interventions is documented in the medical record or other appropriate facility record. All Activity Assistants will be provided with in-serviceeducation that reminds them of the facility's policies for implementing anddocumenting care plan 		

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	<p>On 7/8/14 at 10:00 a.m., Resident #36 was observed in her room, in her chair alone.</p> <p>On 7/9/14 at 9:00 a.m., Resident #36 was observed in the lounge in her chair, the activity was exercise, the residents' chair was turned away from the activity group she did not participate.</p> <p>During an interview with Nurse #2 on 7/10/14 at 1:54 p.m., indicated activity calendar is specific to her floor, and few residents participate in activities, she indicated limited involvement had been noted for several months. Residents are usually in chairs in front of TV.</p> <p>Interview with the Activities Director, on 7/11/14 at 10:26 a.m., indicated the staff do an activity interest assessment for the resident on admission, the activity director does all documentation for ground, first floor. Files are updated in resource meeting every day for updates or changes. Careplans are reviewed and revised on Tuesday afternoon, any issues that are important to the resident are communicated, and care plan changes, An activity participation book is maintained by the floor staff, all activity is documented in the activity participation book. The Activity Director indicated there are several difficulties</p>		<p>interventions, strategies for increasing resident involvement, and engaging residents with multiple levels of ability. The policy for Activity programs has been revised. (Attachment D) In order to monitor the effectiveness of this plan of correction, and in order to make certain that this problem does not arise in the future, the Activities Director will perform quality assurance audits (Attachment C) monthly for the next 90 days, and quarterly thereafter for a period of one year. All corrections for this tag will be completed by August 14th, 2014.</p>		

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F000371 SS=F	<p>with this floor, and activity has been identified this as an issue for this floor.</p> <p>3.1-35(g)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food stored in the freezer, and dry storage area were stored clean, covered and dated. This deficient practice had the potential to effect 86 of 86 residents receiving food from the 1 of 1 kitchen.</p> <p>Findings include:</p> <p>During a tour of the kitchen conducted on 7/7/14 at 10:30 a.m., the following was observed.</p> <p>1. The freezer floor was littered with</p>	F000371	<p>F371</p> <p>This tag was cited due to food storage areas containing items that were not dated or appropriately sealed, and debris being found in storage areas.</p> <p>The cited items were immediately corrected by the Certified Dietary Manager (CDM).</p> <p>In order to identify other potential sanitation concerns, the facility will perform weekly sanitation inspections (Attachment I) which will include inspection of the dry storage areas as well as walk-in refrigerators and freezers. Additionally, stored</p>	08/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2014
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	<p>debris.</p> <p>2. The area behind the wire storage racks in the dry storage area was littered with packages of cereal on the floor and spider webs were observed behind the storage racks.</p> <p>3. A package of fettuccini was opened, uncovered and not dated on the dry storage rack.</p> <p>A review of the procedure for cleaning refrigerator/freezer received from Dietary Manager on 7/15/14 at 11:00 a.m., indicated per the cleaning procedure "... spills are to be cleaned up as they occur...". The schedule also indicated indicated on Sunday the freezer was to be swept and mopped and on Tuesday the store room and paper room was to be mopped and cleaned.</p> <p>During an interview with Dietary employee #3 on 7/7/14 at 11:00 a.m., she indicated the opened food packages should be covered and dated.</p> <p>3.1-21(i)(3)</p>		<p>food items will also be inspected to make certain that all open packages are covered and dated per the Indiana Retail Food Establishment Guidelines for storage of food.</p> <p>The facility's policy for Food Storage (Attachment H) already contains guidelines for sealing, labeling, and dating of stored food items.</p> <p>The Dietary Department's staff will receive in-service education to remind them of sanitation standards, cleaning schedules, and food storage requirements.</p> <p>In addition to the weekly sanitation inspections by the CDM, the RD and/or the Administrator will perform monthly sanitation inspections. These audits will be on-going.</p> <p>All corrections for this tag will be completed by August 14th, 2014.</p>		

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

PRINTED: 08/04/2014
FORM APPROVED
OMB NO. 0938-0391

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	R000 Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor, Inc. provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction:	
R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and			

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	<p>services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure the staff on duty met requirements of first aid training certification. This deficient practice affected 35 of 38 shifts reviewed.</p> <p>Findings include:</p> <p>A review of employee files on 7/11/14 indicated no current appropriate first aid certification for Residential employees.</p> <p>Record review of employee work schedules on 7/15/14 at 1:30 p.m., indicated the facility had multiple shifts without first aid certified staff from 6/28/14 through 7/11/14. Employees with</p>	R000117	<p>R117</p> <p>This tag was cited due to the facility not having staff separately certified for First Aid on all shifts. The facility would like to clarify that our residentially licensed areas are staffed by licensed nurses 24 hours, 7 days per week. Additionally, the residentially licensed portion of the facility is directly connected to the comprehensive and skilled care facility. These areas are also staffed by licensed nurses 24 hours, 7 days per week.</p> <p>There were no residents impacted by this tag.</p> <p>The facility will have the In-Service</p>	08/14/2014	

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R000121	<p>appropriate first aid certification only covered 3 of 38 shifts.</p> <p>During an interview with the In-Service Coordinator on 7/14/14 at 2:30 p.m., she indicated she was BLS certified to teach CPR and First Aid. The first aid training program received by new hires was not a certified first aid training course.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one</p>		<p>Coordinator, who is licensed to teach first aid, provide classes for at least 2 nurses for each shift over a 7-day period (Totaling 10 nurses) as soon as practicable. Afterward, subsequent classes will be provided until all nurses are certified for first aid. Thereafter, classes will be offered on a quarterly basis.</p> <p>The staffing coordinator will mark the daily schedules by the name of the staff member(s) who are certified to provide first aid.</p> <p>The facility will perform weekly audits (Attachment J) of the staffing schedule to make certain that there is coverage by a first aid certified staff member for all shifts. These audits will continue until all nurses are certified. In the future, this training will be provided during new staff orientation for nurses.</p> <p>Corrections for this tag will be completed by August 14th, 2014.</p>	

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	<p>(1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure personnel were screened for tuberculosis (TB) prior to resident contact. This deficient practice affected 1 of 9 employees reviewed for TB skin testing (Dietary Aid #4).</p> <p>Findings include:</p> <p>Record review of employee files on</p>	R000121	<p>R121</p> <p>This tag was cited due to a staff member not having a secondstep skin test (Mantoux) for tuberculosis screening prior to working with residents.</p> <p>There were no residents impacted by this citation.</p> <p>The facility immediately arranged for the staff to come into the facility for a</p>	08/14/2014			

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	<p>07/14/14 at 9:00 a.m., indicated Dietary Aid #4 had a hire date of 05/15/14. A first step TB test was in the personnel record, administered 05/01/14. No second step TB test was completed. No prior employment TB testing was available for review.</p> <p>A timecard report for Dietary Aid #4 was reviewed from 05/15/14 - 07/10/14. Dietary Aid #4 worked 33 shifts since her start date without a second step TB test.</p> <p>During an interview with the Director of Nursing (DoN) on 07/14/14 at 12:25 p.m., she indicated no second step TB testing had been completed for Dietary Aid #4 and no TB testing from a previous employer was available for review.</p> <p>Facility policy and procedure received from Administrator on 7/15/14, titled Mantoux Test, dated March 22, 2001, indicated "...Personnel Affected: All employees and individuals who are contacted by Wesley Manor to perform services for the residents...New employees - Prior to the hiring of a new employee, the Human Resources Manager will schedule that individual for the Mantoux test...If the new employee has had a Mantoux within a year of employment, they need to show proof of the Mantoux given and are only required</p>		<p>first step Mantoux test and TB Questionnaire. This was completed and read prior to the staff member working any additional shifts.</p> <p>In order to identify any other staff whose screenings for tuberculosis were not complete, the facility has audited tracking tools used for all employees and compared them to screening records. Any staff whose tests were missed, either upon hire, or for their annual re-screenings, will have their first step Mantoux test administered and read, and will have a second step after one week. In order to continue working, any staff member whose screening was missed, will have to complete the TB Questionnaire (Attachment K)</p> <p>The Human Resources Manager will perform audits (Attachment L) monthly over the next 90 days, and quarterly thereafter.</p> <p>All corrections for this tag will be completed by August 14th, 2014.</p>				

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R000154	<p>to have the first-step. However, if they do not have proof, they are required to do the two-step Mantoux."</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food stored in the freezer, and dry storage were stored clean, covered and dated. This deficient practice had the potential to effect 114 of 114 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>During a tour of the kitchen conducted on 7/7/14 at 10:30 a.m., the following were observed.</p> <ol style="list-style-type: none"> 1. The freezer floor was littered with debris. 2. The area behind the wire storage racks in the dry storage area was littered with packages of cereal on the floor and spider webs were observed behind the storage 	R000154	<p>R154</p> <p>This tag was cited due to food storage areas containing items that were not dated or appropriately sealed, and debris being found in storage areas.</p> <p>The cited items were immediately corrected by the Certified Dietary Manager (CDM).</p> <p>In order to identify other potential sanitation concerns, the facility will perform weekly sanitation inspections (Attachment I) which will include inspection of the dry storage areas as well as walk-in refrigerators and freezers. Additionally, stored food items will also be inspected to make certain that all open packages are covered and dated per the Indiana Retail Food Establishment Guidelines for storage of food.</p>	08/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
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R000246	<p>racks.</p> <p>3. A package of fettuccini was opened, uncovered and not dated on the dry storage rack.</p> <p>A review of the procedure for the cleaning of the refrigerator/freezer received from Dietary Manager on 7/15/14 at 11:00 a.m., indicated per the cleaning procedure "... spills are to be cleaned up as they occur...".</p> <p>The schedule also indicated on Sunday the freezer was to be swept and mopped and on Tuesday the store room and paper room was to be mopped and cleaned.</p> <p>During an interview with Dietary employee #3 on 7/714 at 11:00 a.m., she indicated the opened food packages should be covered and dated.</p> <p>410 IAC 16.2-5-4(e)(6)</p>		<p>The facility's policy for Food Storage (Attachment H) already contains guidelines for sealing, labeling, and dating of stored food items.</p> <p>The Dietary Department's staff will receive in-service education to remind them of sanitation standards, cleaning schedules, and food storage requirements.</p> <p>In addition to the weekly sanitation inspections by the CDM, the RD and/or the Administrator will perform monthly sanitation inspections. These audits will be on-going.</p> <p>All corrections for this tag will be completed by August 14th, 2014.</p>	

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	<p>Health Services - Deficiency</p> <p>(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure a PRN (as needed) medication was authorized by a nurse prior to administration by a qualified medical assistant (QMA), for 1 of 10 residents reviewed for authorized PRN medications. (Resident #154)</p> <p>Findings include:</p> <p>The clinical record for Resident #154 was reviewed on 7/14/14 at 10:40 a.m. Diagnoses for Resident #154 included, but were not limited to, diabetes type 2, constipation, vitamin B12 deficiency, anxiety, depression, hypothyroidism, insomnia, right hemiparesis, chronic obstructive pulmonary disease.</p> <p>1. The May 2014 Medication Administration Record (MAR) indicated a physician's order, dated 5/12/14, Tylenol 560 mg (milligrams), give 1</p>	R000246	<p>R246</p> <p>This tag was cited due to a Qualified Medication Aide (QMA) not obtaining required authorization from a licensed nurse to administer an "asneeded" medication to one resident.</p> <p>The resident had no ill effects from this occurrence.</p> <p>The QMA has received counseling regarding the policy for administering medications which requires the QMA to request approval for "asneeded" medications, and requires the nurse to follow-up regarding the medication's effectiveness. (Attachment M).</p> <p>All QMA's will receive in-service re-education regarding this policy.</p> <p>Each month, the DON and/or her designee, will perform an audit of Medication Administration Records, to determine whether "As Needed" medications were</p>	08/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2014	
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	<p>tablet orally every 6 hours, as needed, for mild to moderate pain.</p> <p>The May 2014 Medication Administration Record (MAR) indicated on 5/24/2014, at 8:00 a.m., Tylenol was given to Resident #154 by QMA # 1 without prior nurse authorization.</p> <p>The May 2014 Medication Administration Record (MAR) indicated on 5/25/2014, at 5:40 p.m., Tylenol was given to Resident #154 by QMA # 1 without prior nurse authorization.</p> <p>2. The May 2014 Medication Administration Record (MAR) indicated a physician's order, dated 5/120/14, Norco 5/325 mg (milligrams), take 1 tablet orally every 6 hours, as needed, for moderate to severe pain.</p> <p>The May 2014 Medication Administration Record (MAR) indicated on 5/25/2014, at 11:10 a.m., Norco was given to Resident #154 by QMA # 1 without prior nurse authorization.</p> <p>During an interview with the Director of Nursing, (DoN), on 7/14/2014 at 12:25 p.m., she indicated QMA # 1 failed to obtain the proper authorization prior to administering an as needed medication.</p>		<p>administered with appropriate authorizations documented. (Attachment N)</p> <p>All corrections for this tag will be completed by August 14th,2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
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R000349	<p>The facility policy for "Medication: Administration of Medications" dated 4/2/2002 and received 7/14/2014 from the Administrator, indicated P.R.N. medication charting must include reason given and response to drug. QMA's must receive authorization from license nurse to give PRN medication and document authorization on back of drug administration record.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure a PRN (as needed) medication was assessed for effectiveness for 1 of 10 residents</p>	R000349	<p>R349</p> <p>This tag was cited due to lack of documentation to certify that the administration of an "as needed"</p>	08/14/2014

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	<p>reviewed for authorized PRN medications. (Resident #154)</p> <p>Findings include:</p> <p>The clinical record for Resident #154 was reviewed on 7/14/14 at 10:40 a.m. Diagnoses for Resident #154 included, but were not limited to, diabetes type 2, constipation, vitamin B12 deficiency, anxiety, depression, hypothyroidism, insomnia, right hemiparesis, chronic obstructive pulmonary disease.</p> <p>The May 2014 Medication Administration Record (MAR) indicated a physician's order, dated 5/12/14, Tylenol 560 mg (milligrams), give 1 tablet orally every 6 hours, as needed, for mild to moderate pain.</p> <p>The May 2014 Medication Administration Record (MAR) indicated on 5/25/2014, at 5:40 p.m., Tylenol was given to Resident #154 by QMA # 1 and the effectiveness of the medication was not indicated.</p> <p>During an interview with the Director of Nursing, (DoN), on 7/14/2014 at 12:25 p.m., she indicated the effectiveness of the as needed medication was not completed.</p>		<p>medication was effective. This occurred due to a Qualified MedicationAide (QMA) not obtaining required authorization from the licensed nurse to administer the "as needed" medication. Therefore, the licensed nurse was not prompted to assess foreffectiveness.</p> <p>The resident demonstrated no ill effects from this occurrence.</p> <p>The QMA has received counseling regarding the policy for administering medications which requires the QMA to request approval for "asneeded" medications, and requires the nurse to follow-up regarding the medication's effectiveness. (Attachment M).</p> <p>All QMA's will receive in-service re-education regarding this policy. In addition, All licensed nurses will receive reminders of this policy and will be instructed to remind their QMA's of this policy and the need for re-assessment 45 minutes to one hour after a PRN is administered.</p> <p>Each month, the DON and/or her designee, will perform an audit of Medication Administration Records, to determine whether "As Needed" medications were administered with appropriate authorizations documented along with follow-up reassessment. (Attachment N)</p>		

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