

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: February 17, 18, 19, and 20, 2014</p> <p>Facility number: 000368 Provider number: 15E187 AIM number: 100275220</p> <p>Survey team: Heather Tuttle, R.N.- T.C. Yolanda Love, R.N. Cynthia Stramel, R.N.</p> <p>Census bed type: NF: 21 Total: 21</p> <p>Census payor type: Medicaid: 20 Other: 1 Total:21</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 27, 2014, by Janelyn Kulik, RN.</p>	F000000		

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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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was free from physical restraints related to the use of full bed rails while in bed for 1 of 3 residents reviewed for physical restraints of the 4 residents who met the criteria for physical restraints. (Resident #6)</p> <p>Findings include:</p> <p>On 2/19/14 at 6:00 a.m., Resident #6 was observed in bed with both of the bed rails noted in the up position. The bed rails were a full set, indicating they covered the entire length of the bed. At that time, the resident was observed lying in the middle of bed with his eyes closed. There were no attempts by the resident to get out of the bed.</p> <p>The record for Resident #6 was reviewed on 2/19/14 at 1:30 p.m. The resident's diagnoses included, but were not limited to, convulsions,</p>	F000221	<p>F221</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 6 full side rails were replaced with ½ rails. Licensed Nurse performed an updated side rail assessment. The facility does not use restraints but side rails are used as enablers. All residents requiring use of full side rail assistance for turning and repositioning were replaced with half rails. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nurses will follow the restraint criteria for residents who require side rails use which includes the following: completing a side rail assessment and documenting in nurses notes why side rails are used,</p>	03/22/2014			

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	<p>epilepsy, blindness, impaired hearing, anxiety, mental retardation, altered mental status, agitation with behavior problems, and insomnia.</p> <p>Review of the Annual 1/12/14 Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and was severely impaired for decision making. The resident had behaviors of delirium that were continuously present related to inattention and disorganized thinking. He had an altered level of consciousness and his psychomotor behavior was present and fluctuated daily. The resident's mood status indicated he had little interest in doing things and trouble concentrating. The resident was also assessed as having physical behavioral, and verbal behavioral symptoms directed toward staff and others daily. The resident needed extensive assist with bed mobility and transfers with a one person physical assist. The resident was totally dependent on staff for dressing, grooming, and bathing. The resident was assessed as having full use of bed rails daily.</p> <p>Review of the sidereal assessment dated 10/12/13 indicated full bilateral side rails was circled on the</p>		<p>the resident's response and outcome of use of ½ side rails. An In-Service on Side Rail Assessment was held with all charge nurses and daily report to C.N.A.'s during shift to shift report on which resident's use side rails as enablers. 4. How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <p>Assigned Nurse will review her assigned residents for proper side rail usage and monitor for change in condition weekly times one then monthly then quarterly.</p> <p>D.O.N. will assign licensed nurse duties and will audit side rail usage quarterly.</p> <p>D.O.N. will monitor side rail usage log monthly times one month then quarterly thereafter. QA committee will review audits quarterly and determine of audits to continue or if changes need to be made.</p>				

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	<p>assessment and signed by the nurse. There was no other documentation indicating why the resident needed the side rails.</p> <p>Review of the physical restraint assessment dated 1/12/14 indicated the resident had an unsteady gait and had a history of sliding out of the chair. Other interventions used over the last quarter were directed supervision and regular toileting. The restraint assessment indicated the side rails were used as an enabler for the resident to reposition himself in bed. It was determined by the assessment to continue the use of the side rails for enablers for the resident.</p> <p>Review of the current plan of care with the original date of 2/27/13 and updated on 1/12/14 indicated the problem of I need full bilateral side rails to help with my bed mobility. The Nursing approaches were to monitor proper use of side rails, assist resident as needed, and encourage resident to use side rails to aid in repositioning self in bed.</p> <p>Review of the backside of the care plan indicated resident uses full side rails times two when in bed for turning, repositioning and bed</p>				

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	<p>mobility.</p> <p>Interview with CNA #2 on 2/19/14 at 2:45 p.m., indicated she had just starting working at the facility last month. She further indicated the resident will turn himself over while in bed, but rarely grabs onto the side rails. The CNA indicated one person can provide care for him without any problems.</p> <p>Interview with CNA #1 on 2/19/14 2:50 p.m., indicated she works all three shifts and had been working at the facility since September 2013. She further indicated the resident usually raises his bottom up in the air, so we can provide incontinence care. The CNA indicated he rarely grabs onto the side rails. CNA #1 also indicated he will occasionally shake the side rails but never has tried to climb over the them.</p> <p>Interview with the Director of Nursing (DoN) on 2/20/14 at 10:55 a.m., indicated she had spoken to her nursing staff in which they indicated the resident does use the side rails to assist with turning. The DoN further indicated the resident had not tried to climb out of bed and there could be a reduction from full side rails to half side rails. She indicated</p>						

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F000241 SS=D	<p>she had not attempted to reduce the full bed rails in the last year.</p> <p>3.1-26(o)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each residents' dignity was maintained during medication pass and morning care related to residents being called "sweetie", "sweetheart" and "baby" for 3 of 3 residents reviewed for dignity of the 3 residents who met the criteria for dignity. (Residents #6, #7, and #20)</p> <p>Findings include:</p> <p>1. On 2/18/14 at 8:59 a.m., RN #1 was observed preparing medication for Resident #6. As she was getting ready to administer the medication to the resident she stated, "Come on sweetheart open your mouth." She did not address the resident by his name.</p>	F000241	F241 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 6, 7, & 20 were asked if they felt that their dignity was compromised by staff calling them sweetie, sweetheart and baby. None of the resident's stated any concerns. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Resident Council Meeting was held to see if any resident felt that the staff calling them sweetie, sweetheart and baby offended them or felt it was disrespectful. During resident's council no residents expressed any concerns. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All staff was informed	03/22/2014			

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	<p>The record for Resident #6 was reviewed on 2/19/14 at 1:30 p.m. The resident's diagnoses included, but were not limited to, impaired hearing, anxiety, mental retardation, altered mental status, and agitation with behavior problems.</p> <p>Review of the Annual 1/12/14 Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and was severely impaired for decision making.</p> <p>Review of the updated and current plan of care dated 1/12/14 indicated there was no care plan for the resident wanting to be called sweetheart or anything else other than his name.</p> <p>Interview with RN #1 on 2/19/14 3:10 p.m., indicated she had not been informed about addressing the residents as "sweetie" or "sweetheart". She further indicated she should be calling the residents by their real names.</p> <p>2. On 2/18/14 at 9:25 a.m., RN #1 was preparing medications for Resident #7. At that time she had walked into the resident's room to give him his eye drops. As she was</p>		<p>of findings of using names of endearment such as: 1: Honey/Hon 2: Babe/Baby 3: Sweetie Sweetheart 4: Dear/Dearie 5: Love/Lovey Charge nurses asked each resident able to make decisions were asked what name would they like to be called to ensure that staff maintains or enhances the resident's dignity and respect. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Assigned Nurse will review her assigned residents and recorded the resident's preference of name on their face sheet and care plan. Social Service was informed of the nursing staff findings. Social Service will ask what names resident prefers to be called upon admission and information will be placed on the face sheet. Name preference will be reviewed and updated annually by social service. D.O.N. will monitor staff weekly to ensure residents are addressed properly. D.O.N. will orientate newly hired staff on resident name preference. QA committee will review resident name preference monthly then annually. 5. Date completed: 3/22/14</p>		

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	<p>getting ready to administer the eye drops she stated, "Hold your head back sweetie."</p> <p>The record for Resident #7 was reviewed on 2/19/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia, major depression, and atypical psychosis.</p> <p>Review of the 1/24/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and had some moderate impairment for decision making.</p> <p>Review of the current and updated plan of care dated 1/24/14 indicated there was no care plan indicating the resident prefers to be called "sweetie."</p> <p>Interview with RN #1 on 2/19/14 3:10 p.m., indicated she had not been informed about addressing the residents as "sweetie" or "sweetheart". She further indicated she should be calling the residents by their real names.</p> <p>Interview with the Social Service Designee (SSD) on 2/19/14 at 1:00 p.m., indicated the residents were to</p>						

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	<p>be called by their first names</p> <p>3. On 2/17/14 at 8:00 a.m., CNA #1 removed Resident #20 from his bed. As she assisted him to his chair, the CNA said, "Come on baby".</p> <p>The record for Resident #20 was reviewed on 2/18/14 at 10:45 a.m. The resident was admitted on 7/18/12; his diagnoses included, but were not limited to, anxiety, Huntington's Chorea, hyper-sexuality, and agitation with aggressive behaviors.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 2/1/14, indicated the resident was rarely/never understood and needed limited assist with his activities of daily living.</p> <p>Review of the updated 2/1/14 plan of care indicated there was no care plan the resident preferred to be called "Baby."</p> <p>Interview with the Administrator on 2/20/14 at 3:10 p.m., indicated the residents should be called by their first names and no nick names. She</p>				

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F000248 SS=E	<p>also indicated there was only one resident in the facility who should have been called "baby".</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>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, record review, and interview, the facility failed to provide ongoing activities for residents with cognitive impairment, as well as, following the activity calendar for 3 of 3 residents reviewed for activities. (Residents #3, #9, and #19)</p> <p>Findings include:</p> <p>1. On 2/17/14 at 10:02 a.m., Resident #19 was observed in his room wandering aimlessly around. Further observation indicated there was nothing in his room, and his walls were bare. The resident was fidgeting with his bed and mattress.</p>	F000248	F 248 1. Resident 3, 9, 19 were assessed and grouped in the Level 1 category by the Activity Director. The residents are grouped according to their cognitive and social functioning to determine the activity program group in which they could best function. Levels 1 are residents who require verbal cues, total physical assistance, sensory and environmental stimulation, social and behavior management. An example of this resident would be advanced Alzheimer's resident in which the goal is to evoke a verbal or physical response through use of auditory stimulation and touch. Resident 19 is unable to have a television or radio and items on the wall. His family had to remove his television because he would put it	03/22/2014	

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	<p>On 2/17/14 at 11:15 a.m., the resident was observed in his room standing by his bed and staring out the window. Again there was nothing for him to do in his room.</p> <p>On 2/18/14 at 11:07 a.m., the resident was observed standing in the dining room against the wall. He was not participating in anything going on. He was just standing there. No staff were observed to invite the resident to do anything.</p> <p>On 2/19/14 at 10:45 a.m., and 3:05 p.m., the resident was observed standing in the dining room against the wall. The resident was not participating in anything. There were staff noted in the dining room, but they were not interacting with the resident.</p> <p>The record for Resident #19 was reviewed on 2/18/14 at 11:36 a.m. The resident was admitted to the facility on 4/4/12. The resident's diagnoses included, but were not limited to, dementia, syphilis, hallucinations, insomnia, non compliance with medical treatment, and psychosis.</p> <p>Review of the 1/17/14 Quarterly Minimum Data Set (MDS)</p>		<p>under his bed on the floor. The radio had to be removed because he would urinate in it. The additional beds in his room had to be removed prevent injury. Resident would remove the wheels off the beds and try to stack the beds on top of each other. Large pictures in the room will be tried with Resident 19.</p> <p>2. All level 1 residents have the potential of being affected. 3. Residents will be provided with stimulation in small group setting. Examples would be to have the television on, radio playing while waiting for small group activity. Level 1 group activities consist of the following: tactile stimulation, inspirational verses being read to them, aroma therapy, musical stimulation, stimulation to the 5 senses, reading them a story about a large picture... In-service will be held with the activity staff and nursing department and review of the activity program for all residents to ensure stimulation, promote physical and emotional health and improve cognitive status, grouping of residents into levels 1,2, or 3 and the appropriate activities for each level of resident. The resident's participation will be indicated on their activity participation calendar. An effort to recruit volunteers to assist with daily activities is also being pursued.</p> <p>4. The Activity Director will monitor resident participation 3 times weekly times one month</p>		

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	<p>Assessment indicated the resident was not alert and oriented and was severely impaired for decision making. The resident had problems with mood such as inattention and disorganized thinking. The resident needed limited assistance with transfers and locomotion.</p> <p>Review of current and updated plan of care dated 1/17/14 indicated the problem of unable to participate in large group activity due to short attention span and cognitive abilities. The goal was provide 1 to 1 small group relaxed activities. The Nursing approaches were to encourage exercise of small groups, read bible versus, use music therapy and aroma therapy, redirect repetitive behavior, introduce new activity quarterly.</p> <p>Review of Activity Progress Notes dated 11/8/13, indicated the resident does not sit very long in activities. He will participate during ball toss and exercise. His attention span was very short, therefore, he will get up and leave. Will continue to encourage participation.</p> <p>The activity participation book containing the one to one documentation was unavailable for</p>		<p>then monthly thereafter. The administrator/designee will monitor the participation calendar of the level 1 residents weekly to ensure that they will be stimulated and encouraged to evoke a resident response in residents with severe cognitive deterioration. Brief moments of eye contact, or a hand over hand touch, and a calmness of the resident are the responses from some of the Level 1 residents. A new activities director will be pursued by administration. Social Service will encourage community volunteers and vendors interested in visiting the elderly. QA will evaluate the progress of the new activity director recruitment. The activity program will be evaluated monthly until satisfied with new staff for the activity department.</p> <p>5. 3/22/14 UPDATE: 3/24/14</p> <p>1. HOW ACTIVITIES PROGRAM WILL BE MONITORED?</p> <p>The administrator/designee will monitor the scheduled activities according to the activity calendar 3 times weekly for one month then monthly for 3 months then quarterly thereafter.</p>		

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	<p>review.</p> <p>Interview on 2/18/14 at 2:20 p.m., with the Social Service Designee (SSD) indicated there was no activity book with the resident's participation available at this time. She further indicated she thought the CNAs were responsible for completing and filling out the activity participation records for the residents.</p> <p>The Activity Director was not available during the survey (2/17-2/20/14) for interview.</p> <p>Interview with the Administrator on 2/18/14 at 3:15 p.m., indicated the Activity Director had not been at the facility on a full time basis during the day. She further indicated there was no documentation for the participation of residents including one to one visits as well as group participation records.</p> <p>2. On 2/17/14 from 10:00 a.m., until 12:15 p.m., residents were observed seated at tables or in their wheelchairs in the main dining room. At that time, there were no scheduled activities going on. There was one female resident singing hymns to the other residents.</p>		<p>2. Criteria used to determine when the monitoring may be stopped includes the following:</p> <p>Q.A. will weekly evaluate resident's participation in scheduled activities and review activity progress notes of the 6 residents in Level 1 category to evaluate level of participation to ensure that they are stimulated. Q.A. reserves the right to extend the monitoring if deficient practices occur.</p>		

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	<p>On 2/18/14 at 11:03 a.m., there were 15 residents observed in the main dining room. At that time, some were seated at tables and others were just in their wheelchairs. There was no staff in the room, and there was no activity going on in the room. The show Law and Order was on the television set.</p> <p>Continued observation at 11:09 a.m., the Social Service Designee (SSD) came into the dining room and stood by the door entrance. At 11:13 a.m., CNA #2 came into the room and changed the television channel without asking any resident if they wanted the channel changed. She put the news on the television. The CNA then sat down on a chair in the chapel. At no time, were staff observed interacting with the residents or participating in any type of activity.</p> <p>On 2/19/14 at 10:45 a.m., there were 10 residents observed in the main dining room. Some of the residents were seated at tables and others were in their wheelchairs. There were no activities going on at that time. The "Price is Right" was observed on the television.</p> <p>On 2/19/14 at 3:00 p.m., eight</p>						

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	<p>residents were seated in the dining room. There were two CNAs in the room at that time. CNA #1 was walking around talking to a family member and CNA #2 was completing her charting. There was no activity going on at that time. CNA #2 then asked CNA #1 what the activity of "Let's move it" was. CNA #1 indicated she did not know what that meant. Both CNAs were observed talking and interacting to the family member in the dining room, while the residents just sat there.</p> <p>Review of the current February 2014 Activity Calendar indicated the following: Monday 2/17/14 8:00 Coffee/tea 10:30 Spiritual Reading 10:45 Stretch N Tone 11:00 Today in the News 2:00 Afternoon Tea 3:00 Let's Move it 4:00 Bingo</p> <p>Tuesday 2/18/14 8:00 Coffee/tea 10:30 Spiritual Reading 10:45 Stretch N Tone 11:00 Today in the News 2:00 White Castle treats 3:00 Let's Move it</p>				

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	<p>Wednesday 2/19/14 8:00 Coffee/tea 10:30 Spiritual Reading 10:45 Stretch N Tone 11:00 Today in the News 2:00 cheese and crackers 3:00 Let's Move it</p> <p>Interview with the Administrator on 2/20/14 at 12:56 p.m., indicated she was aware there was a problem with the Activity Program and was working on finding a new director.</p> <p>3. On 2/19/14 at 9:34 a.m., 10:20 a.m. and 10:55 a.m., Resident #3 was observed in her crib, sitting upright, hitting the right side of her head with her right hand. The TV was on, but there was no picture, only static on the screen. At 12:45 p.m., the resident was in her chair at a table in the dining room. No staff or other residents were nearby. At 1:30 p.m. and 2:05 p.m., she was in her bed, sitting upright, hitting the side of her head with her hand. The TV was turned off, there was no radio playing.</p> <p>The resident's record was reviewed on 2/19/14 at 9:48 a.m. The resident was admitted to the facility on 1/13/70.</p>						

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	<p>The Quarterly Minimum Data Set (MDS) Assessment dated 1/15/14 indicated diagnoses that included, but were not limited to, unspecified intellectual disabilities and unspecified synovitis and tenosynovitis. She was severely cognitively impaired. She was totally dependant for all activities of daily living (ADL's).</p> <p>A care plan, undated, indicated the resident was unable to participate in group activities due to her cognitive ability. The goal was to provide one on one, or small group activities that involved music or aroma therapy. The approaches were to avoid over stimulation and loud sounds; read books such as the Bible to her; and use music therapy and aroma therapy to calm her.</p> <p>Interview with the Social Service Designee on 2/19/14 at 1:33 p.m., indicated the resident received one on one activities provided by the CNA's, such as tactile stimulation and playing music. She indicated there was no activity log that documented one on one activities. She indicated she was not aware of the TV not working, and would notify the maintenance man.</p>						

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	<p>Interview with CNA #2 on 2/19/14 at 2:05 p.m., indicated she would do range of motion exercises with the residents and, "that was about it".</p> <p>Interview with CNA #1 on 2/19/14 at 2:12 p.m., indicated she worked the midnight shift mostly, so the resident's were sleeping. If working the day shift, she would roll the ball with the resident sometimes, or help her with buttons. She indicated she did not document any activity she did with the resident, and was unaware of an activity log.</p> <p>4. On 2/18/14 at 11:00 a.m. and 12:45 p.m., Resident #9 was observed in her bed, in her room. A TV was on a table on the right side of the bed turned off. Her bed had seizure pads on both side rails which prevented her from being able to see the TV from her position in bed. There was no sound on the TV. At 2:10 p.m., a CNA repositioned the resident in bed. At that time, the TV was on, but there was no sound.</p> <p>On 2/20/14 at 7:55 a.m., the resident was in a Broda chair in the dining room. She was in front of the TV while breakfast was served to the other residents. At 10:10 a.m.,</p>				

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	<p>she was in the Broda chair in her room, the TV was on but there was no sound. At 2:00 p.m. the resident was in bed, the radio was on but it was playing static.</p> <p>The record for the resident was reviewed on 2/18/14 at 11:26 a.m. The resident was admitted to the facility on 5/19/07. Diagnoses included, but were not limited to, Alzheimer's dementia, seizure disorder and aphasia.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment dated 10/30/13, indicated the resident was severely cognitively impaired. Her functional status indicated she was totally dependant for activities of daily living (ADL's) including bed mobility.</p> <p>An undated care plan indicated the problem of being unable to participate in group activities due to cognitive impairment. The goal was to provide one on one, small group activities that were relaxing such as music and aroma therapy. Approaches were to avoid over stimulation; read Bible verses to her; and use music and aroma therapy to calm the resident.</p> <p>Interview on 2/19/14 at 1:33 p.m.</p>				

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	<p>with Social Service Designee indicated the CNA's provided the one on one activities with the residents. She indicated the activity log was not available for review at that time.</p> <p>Interview with CNA #2 on 2/19/14 at 2:05 p.m., indicated she would do range of motion exercises with the residents and, "that was about it".</p> <p>3.1-33(a)</p>				

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F000278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the resident's comprehensive assessment was complete and accurate related to inaccurate coding of behaviors on the Minimum Data Set (MDS) Assessment for 2 of 3 residents reviewed for behaviors</p>	F000278	F278 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The current MDS for Resident 5 & 6 was accurate for the time period indicated for Resident 5 and Resident 6. The D.O.N. has had a relationship with Resident 5 since the 1960's. The D.O.N.	03/22/2014	

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	<p>of the 3 resident's who met the criteria for behaviors. (Residents #5 and #6)</p> <p>Findings include:</p> <p>1. On 2/18/14 at 11:03 a.m., Resident #6 was observed sitting in a geri chair in the main dining room. His eyes were closed and there were no behaviors noted.</p> <p>On 2/18/14 at 2:45 p.m. the resident was observed in his room in the geri chair. His eyes were closed and he was not exhibiting any behaviors.</p> <p>On 2/19/14 at 6:30 a.m., the resident was observed sitting up in a geri chair in the dining room. His eyes were closed and he was not exhibiting any behaviors.</p> <p>On 2/19/14 at 11:00 a.m., the resident was observed sitting in a reclined geri chair. His eyes were closed and he was not exhibiting any behaviors.</p> <p>The record for Resident #6 was reviewed on 2/19/14 at 1:30 p.m. The resident's diagnoses included but were not limited to, convulsions, epilepsy, blindness, impaired hearing, anxiety, mental retardation,</p>		<p>was also present with the family when they received the biopsy report and planned the course of treatment. At the same period her granddaughter was also undergoing the same diagnosis in Mississippi and was scheduled for surgery in December which delayed this resident's treatment. The nursing staff was also aware of a change in daily pattern and gave additional emotional support to her. However all of this should have been documented and communicated by all disciplines. Resident 6 did exhibit behaviors during the morning hours during bathing and during the night according to the night nurse and evening nurse but with the last hospitalizations there was a change in behavior. A need for better communication and documentation of the behaviors between all disciplines has been addressed as a deficient area. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Potential to affect all residents exhibiting behaviors. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. MDS In –Service will be presented with focus on tools used to ensure accuracy of assessments. Examples: ADL Grids, Food and Fluid Intake, Weight Logs, Behavior Logs,</p>		

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	<p>altered mental status, agitation with behavior problems, and insomnia.</p> <p>Review of the Annual 1/12/14 Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and was severely impaired for decision making. The resident had behaviors of delirium that were continuously present related to inattention and disorganized thinking. He had an altered level of consciousness and his psychomotor behavior was present and fluctuated daily. The resident's mood status indicated he had little interest in doing things and trouble concentrating. The resident was also assessed as having physical behavioral, and verbal behavioral symptoms directed toward staff and others daily. The resident needed extensive assist with bed mobility and transfers with a one person physical assist. The resident was totally dependent on staff for dressing, grooming, and bathing.</p> <p>The resident was admitted to the hospital on 12/31/13 returned to the facility on 1/4/14. He was again admitted to the hospital on 2/9/14 and returned on 2/11/14 for syncope episodes.</p>		<p>Depression Screening and other MDS Assessment Tools. The D.O.N. is responsible for the MDS process and training staff to the new Point Click Care Computer System for MDS processing. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. will review MDS for accuracy related to behaviors. Director of Nursing will audit MDS for accuracy prior to transmission. The nursing staff will participate in ongoing training to learn the new computerized Point Click Care Documentation. Nursing staff will be in-serviced by webinar presentations ongoing to ensure accuracy. QA will review the effectiveness of the new Point Click Care computerized program and make recommendation as needed. 5. Date completed: 3/22/14 UPDATE: 3/24/14</p> <p>1. HOW WERE RESIDENTS REVIEWED THAT WOULD BE AFFECTED?</p> <p>All 7 residents with behaviors were reviewed and care plans updated by assigned licensed nurse.</p> <p>2. MEASURES TAKEN TO</p>		

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	<p>Review of the Nursing Progress Notes for the months of November and December 2013 and for the months of January and February 2014 indicated there was no evidence of any documented behaviors of physical and verbal aggression.</p> <p>There was no evidence of any documented behavior sheets or behavior monitoring.</p> <p>Interview with CNA #2 on 2/19/14 at 2:45 p.m., indicated the resident had not had any behaviors in the last month. She further indicated she had just been working at the facility for a month.</p> <p>Interview with CNA #1 on 2/19/14 at 2:50 p.m., indicated the resident had not had any behaviors in a long time. She indicated once in a while he would yell if his liquids had dripped on him. She further indicated the resident does not spit on the floor or yell and be rude to others anymore.</p> <p>Interview with the Social Service Designee on 2/19/14 at 2:52 p.m., indicated the resident had not had any behaviors in a long time. She</p>		<p>CORRECT DEFICIENT PRACTICE.</p> <p>All nursing staff and social service in-serviced on behaviors documentation and importance of communication between departments.</p> <p>All residents care plans were reviewed by licensed nurse according to their assignment.</p> <p>Social Service Designee will be included in weekly nurse behavior conference.</p> <p>3. MONITORING SYSTEM AND FREQUENCY AND NUMBER OF RESIDENTS REVIEWED.</p> <p>The D.O.N. will review 4 residents with behaviors care plans and behavior logs weekly during weekly meeting</p>		

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	<p>further indicated he does not do much yelling anymore.</p> <p>Interview with the Director of Nursing on 2/18/14 at 10:55 a.m., indicated the resident had not had a lot behaviors since his hospitalizations. She further indicated the MDS was probably inaccurately coded related to his behaviors.</p> <p>2. On 2/18/14 at 11:15 a.m., Resident #5 was observed in the dining room. She was singing gospel songs while other residents were seated around her.</p>		<p>with nursing staff and social service.</p> <p>4. Criteria used to determine when the monitoring may be stopped includes the following:</p> <p>Monitoring will be ongoing by nursing department and social service. Q.A. will evaluate the practice to ensure this corrects prior deficiency. The effectiveness will be determined by all residents exhibiting behaviors has a detailed care plan denoting type of behavior and behavior log will determine frequency of behavior displayed. Optimal outcome is for the behavior to stop but for the cognitively impaired a decrease in behavior episodes would implicate success.</p>		

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	<p>On 2/20/14 at 7:55 a.m., the resident was observed in the dining room. She was fully dressed, smiling, talking to staff and other residents.</p> <p>The record for the resident was reviewed on 2/19/14 at 8:45 a.m. The resident was admitted to the facility on 8/31/09. The resident's diagnoses from the February 2014 Physician Order Statement included, but were not limited to, right mastectomy and stroke.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 12/13/13 indicated the resident was feeling down, depressed or hopeless 12-14 days in the past two weeks.</p> <p>Review of the Social Service notes on 11/26/13, indicated the resident had not shown signs of depression since her breast cancer diagnoses. She continued with her daily routine and said, "baby, I'm good, it's all in the hands of the good master."</p> <p>A Social Service note dated 1/15/14 indicated the resident did not show any signs or symptoms of depression. Further review of Social Service notes from 4/30/13 through 2/18/14, did not have any</p>			

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F000279 SS=D	<p>documentation of depression.</p> <p>Interview with the Director of Nursing on 2/20/14 at 11:00 a.m., she indicated the resident was not depressed and the MDS had been coded incorrectly.</p> <p>3.1-31(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 ensure each resident had a comprehensive care plan related to nutrition for</p>	F000279	F 279 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The resident 13, 18 & 19 care	03/22/2014			

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	<p>underweight residents and for psychotropic medication for 2 of 3 residents reviewed for nutrition and for 1 of 5 residents reviewed for unnecessary medications. (Resident #13, #18, and #19)</p> <p>Findings include:</p> <p>1. The record for Resident #19 was reviewed on 2/18/14 at 11:36 a.m. The resident was admitted to the facility on 4/4/12. The resident's diagnoses included, but were not limited to, dementia, syphilis, hallucinations, insomnia, non compliance with medical treatment, and psychosis.</p> <p>Review of the 1/17/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented. The resident needed limited assistance with eating with one person physical help. The resident had no weight loss and was 72 inches tall and weighed 138 pounds.</p> <p>Review of the Registered Dietitian (RD) Progress Notes dated 7/27/13 indicated the resident's weight for July was 134 pounds. The resident's weight for June was 141 pounds. The resident's Body Mass</p>		<p>plan was updated to include underweight and psychotropic medications. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All current MDS weight were reviewed. No other resident had the potential of being affected. All residents care plans were reviewed in reference to psychotropic medications and weight loss. It was explained to the surveyors that we had implemented Point Click Care system using care plans and MDS assessments in January and staff had only been trained to develop the care plan from the triggered areas. The next training would include how to add additional areas to be included in the care plan that were not triggered through the MDS.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Care plans have been divided with the licensed nursing staff. It is that nurse's responsibility to keep the care plan updated weekly according to the resident's needs, changes in medication and changes in condition. The D.O.N. will monitor care plans monthly according to quarterly schedule coordinated with the MDS calendar. The entire licensed nursing staff will meet weekly to discuss residents to</p>		

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	<p>Index (BMI) was 18 (underweight status).</p> <p>Review of the 2/9/14 RD Progress Note indicated the resident's weight was 136 pounds and his current BMI was 18.5.</p> <p>Review of the annual Nutritional Assessment form completed by the RD dated 4/13/13 indicated the resident weighed 140 pounds and had a BMI of 19. The RD indicated the BMI was on the lower end.</p> <p>Review of the current plan of care dated 1/17/14 indicated there was no plan of care for the resident's underweight status with a low BMI of 18.</p> <p>Interview with the Director of Nursing on 2/20/14 at 10:55 a.m., indicated there should have been a care plan for the resident's underweight status with a low BMI.</p>		<p>ensure all of the residents needs are address and to promote continuity of care from shift to shift during report. 4.How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. is responsible for continue training of the new Point Click Care system for development of care plans and updating care plans. D.O.N. will monitor care plans weekly for 1 month then according to MDS due date. D.O.N. will continue training of nursing staff to new computerized system with Point Click Care ongoing. Q.A. Committee will monitor effectiveness of the Point Click Care System and receive information of residents at risk for weight loss and psychotropic medications. 5.3/22/14 UPDATE: 3/24/14</p> <p>1. Criteria used to determine when the monitoring may be stopped includes the following:</p> <p>Dietician will determine if resident's weights are stabilized and has reached their ideal weight according to the resident's history and disease process.</p> <p>Weights and care plans for underweight residents will be</p>		

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			<p>monitored by the D.O.N. weekly and Dietician bi-weekly this is ongoing.</p> <p>D.O.N. will monitor behaviors and medication weekly.</p> <p>Pharmacist Consultant and psychiatric service will monitor medication and behaviors monthly.</p> <p>The monitoring for residents weights and psychotropic medication use will be ongoing but Q.A. will monitor the effectiveness of our practice to prevent any deficient practices. The dietician consultant reports will be reviewed for residents underweight. The pharmacist consultant reports will be reviewed for residents with behaviors on psychotropic medications. It will be determined how the new psychiatric services will be reviewed when the services are contracted but the</p>		

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	<p>2. The record for Resident #13 was reviewed on 2/19/14 at 1:05 p.m. The resident was admitted to the facility on 10/2/08. The resident's diagnoses on the February 2014 Physician Order Statement (POS) included, but were not limited to, Alzheimer's disease, depression and kidney disease.</p> <p>Review of the resident's monthly weights included as follows: February 2013- 115 pounds April 2013- 113 pounds May 2013- 105 pounds June 2013- 104 pounds July 2013- 101 pounds October 2013- 102 pounds December 2013- 99 pounds February 2014- 103 pounds</p> <p>A Dietary progress note dated 5/25/13 indicated a weight loss of 8 pounds from the previous month. A recommendation was made for super cereal at breakfast every day. The Dietary note indicated the</p>		<p>effectiveness of the practice to correct this past deficiency will be evaluated by QA and depending on reported concerns by the committee will determine if further monitoring is needed.</p>		

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	<p>Physician had ordered the super cereal for breakfast on 5/25/13.</p> <p>A Dietary progress note dated 6/4/13 indicated the resident was started on super mashed potatoes with lunch and dinner, and house supplement to help stabilize weight.</p> <p>Review of the February 2014 POS indicated the resident was to receive 1 can of house supplement daily due to weight loss</p> <p>There was no care plan in the record related to the resident's weight loss or additional nutritional requirements.</p> <p>Interview with the Director of Nursing on 2/18/14 at 3:14 p.m. indicated a care plan related to nutritional needs or weight loss had not been initiated.</p> <p>3. The record for Resident #18 was reviewed on 2/18/14 at 2:00 p.m. The resident was admitted to the facility on 9/18/12.</p> <p>The February 2014 Physician Order Statement (POS) diagnoses included, but were not limited to, mental disorder and hepatic encephalopathy.</p>				

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	<p>The February 2014 Medication Administration Record included Risperdone (an anti-psychotic) 1.5 milligrams (mg) daily to treat aggressive behaviors.</p> <p>A Physician Order dated 8/8/13 indicated Risperdone 1.5 mg daily.</p> <p>There was no care plan in the resident's record related to use of anti-psychotic medications.</p> <p>Interview with the Director of Nursing on 2/18/14 at 3:14 p.m., indicated there was no care plan for anti-psychotic medications for the resident.</p> <p>3.1-35(a)</p>			

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F000280 SS=A	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to invite the resident's family member to the care conference for 1 of 1 resident's reviewed for participation in care planning of the 1 resident who met the criteria for participation in care planning. (Resident #21)</p> <p>Findings include:</p> <p>Interview with Resident #21's mother on 2/17/14 11:15 a.m., indicated she had never been invited to any care planning conferences.</p> <p>Interview with the resident's mother</p>	F000280	F 280 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 21's mother has been at care conferences before and additional conferences when the medical director was present. The 1/10/14 conference the mother was unable to attend due to the snow blizzard like conditions but conference was held with her the next Tuesday however Social Service should have documented the situation. Conference was held with Social Service Department, D.O.N. and Administrator to discuss the procedure of inviting the family and residents to care	03/22/2014			

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	<p>on 2/18/14 at 2:10 p.m., indicated there had been a care planning conference for her son on 1/10/14. She again indicated she had not been invited to attend.</p> <p>The record for Resident #21 was reviewed on 2/18/14 at 1:46 p.m. The resident was admitted to the facility 7/30/12. The resident's responsible party was his mother.</p> <p>Review of Social Service section in the record indicated there was a care plan conference invitation in the chart with no address noted on the paper. The invitation indicated the resident's care plan conference was to be held on 1/10/14 at 2:00 p.m.</p> <p>Review of Social Service Progress Notes indicated there was no documentation on 1/10/14 indicating a care conference was held.</p> <p>Interview with the Social Service Designee (SSD) on 2/18/14 at 2:15 p.m., indicated "I place a sign up in the resident's room or tell the family about the conference when they are at the facility." She indicated his mother was not in attendance at the last meeting. She further indicated "I mail the letter to the families but do not keep a log of when I mail</p>		<p>conferences. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Social Service reviewed their invitations to the family members to the care conference and no other residents were affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Care plans will assign by the D.O.N. to the charge nurses then reviewed by the D.O.N. In-service will be held with all charge nurses regarding accurate and updating care plans by the D.O.N. Social Service log sheet will be developed to include Residents Name, Date of Care Conference and Time, Responsible Party of whom Social Service Designee has spoken to and Yes or No if they will be attending the care conference. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Administrator will monitor care conference log weekly times one month then quarterly then refer to Q.A. Committee D.O.N./D.O.N. Designee will review care plans according to the MDS schedule and new orders and changes that occur with the residents ongoing. Care Plans are reviewed each week according to MDS schedule. Weekly audits will be</p>		

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F000282 SS=E	<p>them." She indicated there was no way of indicating the care conference letter was mailed.</p> <p>3.1-35(c)(2)(C)</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, record review, and interview, the facility failed to ensure Physician Orders and/or the plan of care was followed related providing one to one activities, serving super mashed potatoes, and changing a foley catheter monthly for 3 of 3 residents reviewed for activities, 1 of 3 residents reviewed for nutrition, and for 1 of 1 residents reviewed for foley catheter use. (Residents #3, #9, and #19)</p> <p>Findings include:</p> <p>1. On 2/17/14 at 10:02 a.m., Resident #19 was observed in his room wandering aimlessly around. Further observation indicated there was nothing in his room, and his walls were bare. The resident was</p>	F000282	<p>performed according to MDS schedule. Q.A. Committee will review audits monthly. 5. 3/22/14</p> <p>F 282</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 3, 9, 19 were assessed and grouped in the Level 1 category by the Activity Director. The residents are grouped according to their cognitive and social functioning to determine the activity program group in which they could best function. Level 1 residents who require verbal cues, total physical assistance, sensory and environmental stimulation, social and behavior management. An example of this resident</p>	03/22/2014			

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	<p>fidgeting with his bed and mattress.</p> <p>On 2/17/14 at 11:15 a.m., the resident was observed in his room standing by his bed and staring out the window. Again there was nothing for him to do in his room.</p> <p>On 2/18/14 at 11:07 a.m., the resident was observed standing in the dining room against the wall. He was not participating in anything going on. He was just standing there. No staff were observed to invite the resident to do anything.</p> <p>On 2/18/14 at 12:40 p.m., Resident #19 was observed sitting at the table eating his lunch. The resident was served barbeque pork, sweet mashed potatoes, cabbage, and roll and butter. The resident was not served super mashed potatoes.</p> <p>On 2/19/14 at 10:45 a.m., and 3:05 p.m., the resident was observed standing in the dining room against the wall. The resident was not participating in anything. There were staff noted in the dining room, but they were not interacting with the resident.</p> <p>On 2/19/14 at 12:30 p.m., the resident was observed seated at the</p>		<p>would be advanced Alzheimer's resident in which the goal is to evoke a verbal or physical response through use of auditory stimulation and touch.</p> <p>Resident 19 is unable to have a television or radio and items on the wall. His family had to remove his television because he would put it under his bed on the floor. The radio had to be removed because he would urinate in it. The additional beds in his room had to be removed prevent injury. Resident would remove the wheels off the beds and try to stack the beds on top of each other. Large pictures in the room will be tried with Resident 19.</p> <p>Resident 9 foley was changed monthly the designated nurse for this works the 3-11 shift. The L.P.N. thought she had done the proper documentation on the back of</p>		

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	<p>table in the main dining room finishing his lunch meal. At that time, the resident was served french fries and was not served super mashed potatoes.</p> <p>Interview with the Dietary Cook at the time, indicated the resident was not served super mashed potatoes. The Cook further indicated the resident had not been served the super mashed potatoes all week. He indicated he followed the tray cards and on the resident's tray card super mashed potatoes was not listed.</p> <p>The record for Resident #19 was reviewed on 2/18/14 at 11:36 a.m. The resident was admitted to the facility on 4/4/12. The resident's diagnoses included, but were not limited to, dementia, syphilis, hallucinations, insomnia, non compliance with medical treatment, and psychosis.</p> <p>Review of the 1/17/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented. The resident needed limited assistance with eating with one person physical help. The resident had no weight loss and was 72 inches tall and</p>		<p>the TAR's. However the L.P.N. questioned only works on-call 1-2 days a month. The questioning occurred on 2/17/14. Foley for Resident 9 became dislodged evening of 2/17/14 and physician discontinued it, but deficient practice requires an in-service to be held on proper foley documentation.</p> <p>Dietary Card was corrected and a super mashed potato was added. Recipe for super mashed potatoes was reviewed with the cook and the necessity of following the orders on the tray cards and proper recipes.</p> <p>2.All level 1 residents have the potential of being affected.</p> <p>No other resident had the potential of being affected. No residents have a foley catheter is present in the facility.</p>		

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	<p>weighed 138 pounds.</p> <p>Review of current and updated plan of care dated 1/17/14 indicated the problem of unable to participate in large group activity due to short attention span and cognitive abilities. The goal was provide 1 to 1 small group relaxed activities. The Nursing approaches were to encourage exercise of small groups, read bible versus, use music therapy and aroma therapy, redirect repetitive behavior, introduce new activity quarterly.</p> <p>Review of the current 2/2014 recap indicated the Physician's Order with the original date of 4/8/13 indicated super mashed potatoes for lunch.</p> <p>The activity participation book containing the one to one documentation was unavailable for review.</p> <p>Interview on 2/18/14 at 2:20 p.m., with the Social Service Designee (SSD) indicated there was no activity book with the resident's participation available at this time. She further indicated she thought the CNAs were responsible for completing and filling out the activity participation records for the residents.</p>		<p>All 2 residents receiving super mashed potatoes were affected.</p> <p>3.Residents will be provided with stimulation in small group setting. Examples would be to have the television on, radio playing while waiting for small group activity. Level 1 group activities consist of the following: tactile stimulation, inspirational verses being read to them, aroma therapy, musical stimulation, stimulation to the 5 senses, reading them a story about a large picture. In-service will be held with the activity staff and nursing department and review of the activity program for all residents to ensure stimulation, promote physical and emotional health and improve cognitive status, grouping of residents into levels 1,2, or 3 and the appropriate activities for each</p>				

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	<p>The Activity Director was not available during the survey (2/17-2/20/14) for interview.</p> <p>Interview with the Social Service Designee on 2/19/14 at 2:00 p.m., indicated the resident's tray card was just updated and changed, and he should have been receiving the super mashed potatoes.</p>		<p>level of resident. The resident's participation will be indicated on their activity participation calendar. An effort to recruit volunteers to assist with daily activities is also being pursued.</p> <p>In-service held on proper documentation of foley catheter changes and also putting information on the shift to shift report so that each nurse will be aware of the foley change.</p> <p>The need for a new cook has been determined by administration but the entire nursing staff and dietary staff will be in-service on the importance of added nutritional benefits to the residents requiring items such as super mashed potatoes and super cereal. Recipes for super mashed potatoes and super cereal will be reviewed with both the dietary and nursing staff.</p>	

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			<p>4.The Activity Director will monitor resident participation 3 times weekly times one month then monthly thereafter. The administrator/designee will monitor the participation calendar of the level 1 residents weekly to ensure that they will be stimulated and encouraged to evoke a resident response in residents with severe cognitive deterioration. Brief moments of eye contact, or a hand over hand touch, and a calmness of the resident are the responses from some of the Level 1 residents.</p> <p>A new activities director will be pursued by administration.</p> <p>Social Service will encourage community volunteers and vendors interested in visiting the elderly.</p>		

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			<p>QA will evaluate the progress of the new activity director recruitment. The activity program will be evaluated monthly until satisfied with new staff for the activity department.</p> <p>Residents with foley cath will be monitored monthly according to when their cath should be changed by the D.O.N. until foley is discontinued or ongoing if foley cath remains.</p> <p>Q.A. will receive a census report on how many residents require foley catheters.</p> <p>The F.S.S. and licensed nursing staff will be responsible for each ensuring each resident receives the required super mashed potatoes and super cereal daily while serving meal trays.</p>	

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			<p>The dietician will in-service the dietary department and require a return demonstration on the proper preparation of the super mashed potatoes and super cereal. She will monitor this process monthly for 2 months then quarterly thereafter.</p> <p>The D.O.N. will review recipe for super mashed potatoes and super cereal with the entire nursing staff and the importance of the resident receiving the required food items.</p> <p>FSS and D.O.N. will monitor dietician recommendations during each facility visit. This will be an ongoing practice.</p> <p>Administrative Designee will monitor super mashed potatoes and super cereal 3</p>	

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	<p>2. On 2/18/14 at 11:00 a.m. and 12:45 p.m., Resident #9 was observed in her bed, in her room. A TV was on a table on the right side of the bed and turned off. Her bed had seizure pads on both side rails which prevented her from being able to see the TV from her position in bed. There was no sound on the TV. At 2:10 p.m., a CNA repositioned the resident in bed, at that time, the TV was on, but there was no sound.</p> <p>On 2/20/14 at 7:55 a.m., the resident was in a Broda chair in the dining room. At that time, she was in front of the TV while breakfast</p>		<p>times a week for one month then monthly for 3 months then quarterly thereafter.</p> <p>Q.A. will monthly monitor the effectiveness of the administration of super mashed potatoes and super cereal as it relates to weight gain or weight stabilization.</p> <p>5.3/22/14</p>		

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	<p>was served to the other residents. At 10:10 a.m., she was in the Broda chair in her room, the TV was on but there was no sound. At 2:00 p.m. the resident was in bed, the radio was on but it was playing static.</p> <p>The record for the resident was reviewed on 2/18/14 at 11:26 a.m. The resident was admitted to the facility on 5/19/07. The resident's diagnoses included, but were not limited to, Alzheimer's dementia, seizure disorder and aphasia.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment dated 10/30/13, indicated the resident was severely cognitively impaired. Her functional status indicated she was totally dependant for activities of daily living (ADL's) including bed mobility.</p> <p>An undated care plan indicated the problem of being unable to participate in group activities due to cognitive impairment. The goal was to provide one on one, small group activities that were relaxing such as music and aroma therapy. Approaches were to avoid over stimulation; read Bible verses to her, and use music and aroma therapy to calm the resident.</p>						

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	<p>Interview on 2/19/14 at 1:33 p.m. with Social Service Designee indicated the CNA's provided the one on one activities with the residents. She indicated the activity log with the documented activities was unavailable for review.</p> <p>Interview with CNA #2 on 2/19/14 at 2:05 p.m., indicated she would do range of motion exercises with the residents and, "that was about it".</p> <p>A Physician order dated 11/20/13, indicated insert a Foley (urinary) catheter and change it monthly and as needed for leakage or dislodgement.</p> <p>Interview with the Director of Nursing on 2/20/14 at 11:00 a.m., indicated Foley catheter changes should be documented on the back of the Treatment Administration Record (TAR) or Medication Administration Record (MAR).</p> <p>There was no documentation on the November or December 2013, January or February 2014, MAR or TAR indicating the Foley catheter had been changed.</p> <p>Interview with LPN #1 on 2/20/14 at 12:30 p.m. indicated she had not</p>						

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	<p>changed the resident's Foley catheter since she had it. She was unaware if another nurse had changed it.</p> <p>3. On 2/19/14 at 9:34 a.m., 10:20 a.m. and 10:55 a.m., Resident #3 was observed in her bed, sitting upright, hitting the right side of her head with her right hand. The TV was on, but there was no picture, only static. At 12:45 p.m., the resident was in her chair at a table in the dining room. No staff or other residents were nearby. At 1:30 p.m. and 2:05 p.m., she was in her crib, sitting upright, hitting the side of her head with her hand. The TV was turned off, there was no radio playing.</p> <p>The resident's record was reviewed on 2/19/14 at 9:48 a.m. The resident was admitted to the facility on 1/13/70.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 1/15/14 indicated diagnoses that included, but were not limited to, unspecified intellectual disabilities and unspecified synovitis and tenosynovitis. She was severely cognitively impaired. She was totally dependant for all activities of daily</p>						

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	<p>living (ADL's).</p> <p>A care plan, undated, indicated the resident was unable to participate in group activities due to her cognitive ability. The goal was to provide one on one, or small group activities that involved music or aroma therapy. The approaches were to avoid over stimulation and loud sounds; read books such as the Bible to her; and use music therapy and aroma therapy to calm her.</p> <p>Interview with the Social Service Designee 2/19/14 at 1:33 p.m., indicated the resident received one on one activities provided by the CNA's, such as tactile stimulation and playing music. She indicated there was no activity log that documented one on one activities. She indicated she was not aware of the TV not working, and would notify the maintenance man.</p> <p>Interview with CNA #2 on 2/19/14 at 2:05 p.m., indicated she would do range of motion exercises with the residents, and, "that was about it".</p> <p>Interview with CNA #1 on 2/19/14 at 2:12 p.m., indicated she worked the midnight shift mostly, so the resident's were sleeping. If working</p>						

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F000312 SS=D	<p>the day shift, she would roll ball with the resident sometimes, or help her with buttons. She indicated she did not document any activity she did with the resident, and was unaware of an activity log.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure each resident who was dependent with activities of daily living received the necessary services to maintain dressing related to being dressed in clothes without holes in them for 2 of 3 residents reviewed for activities of daily living of the 6 residents who met the criteria for activities of daily living. (Residents #6 and #7)</p> <p>Findings include:</p> <p>1. On 2/17/14 at 9:57 a.m., Resident #6 was observed with several holes in his shirt below the buttons.</p>	F000312	<p>F 312</p> <p>1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 6 and 7 clothing inventory was performed by social service designee. Laundry department was re-instructed not to bring up clothing that is torn or has holes.</p> <p>C.N.A.'s instructed not to dress resident's in any torn clothing. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what</p>	03/22/2014			

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	<p>On 2/17/14 at 1:28 p.m., the resident was still observed wearing the same shirt with holes noted in the front.</p> <p>On 2/19/14 at 6:30 a.m., the resident was observed up in a geri chair in the dining room seated at a table. CNA #4 was present and interviewed at that time. She indicated most of the resident's clothes have holes in them. She indicated that was all he had to wear and that was all that was in his closet.</p> <p>Interview with the Social Service Designee on 2/19/14 at 9:00 a.m., indicated the resident should not be wearing clothes with holes in them.</p> <p>The record for Resident #6 was reviewed on 2/19/14 at 1:30 p.m. The resident's diagnoses included but were not limited to, convulsions, epilepsy, blindness, impaired hearing, anxiety, mental retardation, altered mental status, and agitation with behavior problems.</p> <p>Review of the 1/12/14 Annual Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and was</p>		<p>corrective action will be taken. No other residents were noted to be deficient. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An In-Service with Laundry department about following proper procedure for clothing replacement.</p> <p>An In-Service with C.N.A.'s and Licensed Nurses on Proper Dressing of Residents during ADL care.</p> <p>In-service held with Social Service Designee on properly assessing clothing needs of each resident and notifying family member.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur. The charge nurse will be responsible for checking for proper dressing of each resident daily.</p> <p>The laundry department will be responsible for not sending</p>		

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	<p>severely impaired for decision making. The resident was totally dependent on staff for dressing.</p> <p>Review of the current plan of care dated 1/12/14 indicated there was no care plan for the resident preferring to wear clothes with holes in them.</p> <p>2. On 2/17/2014 at 10:09 a.m., Resident #7 was observed wearing sweat pants that had holes in them.</p> <p>On 2/17/14 at 1:25 p.m., the resident was still observed wearing the same pants with holes noted in the front.</p> <p>On 2/18/14 at 11:10 a.m., the resident was seated in the main dining room. At that time, he was observed wearing a shirt with holes noted on the front.</p> <p>On 2/18/14 at 1:50 p.m., and 3:30 p.m., the resident was seated in the dining room at a table, he was still wearing the same shirt with holes in it.</p> <p>On 2/19/14 at 6:30 a.m., the resident was up and dressed and seated in the main dining room at the table. He was dressed in street</p>		<p>up torn clothing and placing it in resident's closet instead the clothing will be bagged with a clothing replacement needed sheet and given to social service designee.</p> <p>The social service designee will sign that she has received the clothing replacement form and contact the family for new clothing items. It is recommended that the facility has at least 7 days of clothing for each resident. Social Service will record in progress note the clothing request and the family response.</p> <p>The D.O.N. will meet weekly with licensed nursing staff to identify if problems noted with C.N.A.'s properly dressing residents.</p> <p>The D.O.N. will monitor residents clothing list request and communicate social service about resident clothing needs and family response monthly for 3 months then quarterly thereafter.</p>				

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	<p>clothes and his pants had holes in them. CNA #4 was present and interviewed at that time. She indicated most of his clothes have holes in them. She further indicated his daughter had not been in to see him in awhile. She indicated his closet was full of clothes with holes in them.</p> <p>The record for Resident #7 was reviewed on 2/19/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia, major depression, atypical psychosis, and anxiety.</p> <p>Review of the 1/24/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented had some moderate impairment for decision making. The resident was totally dependent on staff for dressing.</p> <p>Review of the updated 1/24/14 care plan indicated the resident was dependent for bathing due to hemiplegia. The goal was continues to require total assist with bathing, dressing and grooming.</p> <p>Interview the Social Service Designee on 2/19/14 at 9:00 a.m., indicated the resident should not</p>		<p>Q.A. will monthly monitor clothing request to family members and their response. House clothing will be used on resident's until family can bring provide proper clothing.</p> <p>5. 3/22/14</p>		

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F000322 SS=D	<p>had been dressed with clothes that had holes in them</p> <p>Interview with the Director of Nursing on 2/19/14 at 9:00 a.m., indicated she had instructed CNA #4 to get clothes from the stock clothing in the basement.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's Percutaneous Endoscopic Gastrostomy (PEG) tube was properly checked for placement prior to medication administration. The facility also failed to ensure</p>	F000322	F 322 1.Medication administration via peg tube policy from the pharmacy was given to LPN #2 for review. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. 1 other resident in the facility had the potential to be	03/22/2014			

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	<p>medication was dissolved prior to administration through the PEG tube for 1 of 1 residents observed with a PEG tube during medication pass. (Resident #9)</p> <p>Findings include:</p> <p>On 2/19/13 at 6:30 a.m., LPN #2 was observed pouring and preparing medications for Resident #9's PEG tube. The LPN crushed both pills and placed them into a plastic cup. The LPN then drew up a liquid medication into a syringe and placed it into another plastic cup. The LPN proceeded to unclamp the PEG tube and pushed a five cubic centimeters air bolus into the tube with the piston syringe. He did not listen or check for placement using a stethoscope. He placed 30 cc of water first down the PEG tube and then he added the crushed medicine which was undissolved down the tube. He did not dissolve the crushed pills before placing them down the tube.</p> <p>The record for Resident #9 was reviewed on 2/20/14 at 10:14 a.m. The resident's diagnoses included, but were not limited to Alzheimer and aphasia.</p>		<p>affected by the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-Service was held with nursing staff on 2/20/14 on proper peg tube placement, medication administration via peg tube and flushing of peg tube according to pharmacy policy and again on 2/25/14. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N will require a skills test to be completed on the following: proper peg tube placement, medication administration via peg tube and flushing of peg tube. Proper peg tube placement, medication administration via peg tube and flushing of peg tube will be monitored times one week then quarterly in 3 months. Skills test will be required to be performed on all licensed nurses upon the start of employment and semi-annually thereafter. Pharmacy Consultant will monitor proper peg tube placement, medication administration via peg tube and flushing of peg tube policy and review annually for updates. QA will review skills test of all licensed staff to ensure they understand the proper procedure for proper peg tube placement, medication administration via peg tube and flushing of peg tube. D.O.N. will notify Q.A. if deficient practices detected. 5.</p>		

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	<p>Review of Physician Orders dated 2/9/14 indicated to discontinue pleasure feeding the resident was NPO (nothing by mouth).</p> <p>Review of the current and undated enteral tube medication administration procedures provided by the Director of Nursing on 2/20/14 at 11:30 a.m., indicated crush tablets and dissolve in 10-15 milliliters of water or other appropriate liquid. Verify tube placement; insert a small amount of air into the tube with the syringe and listen to the stomach with a stethoscope or gurgling sounds.</p> <p>Interview with the Director of Nursing (DoN) on 2/20/14 at 10:55 a.m., indicated the nurse should have checked placement using an air bolus and the stethoscope. She then indicated he should have diluted the powdered pill medication first before administering it down the tube.</p> <p>3.1-44(a)(2)</p>		<p>Completion Date: 3/22/14 UPDATE: 3/24/14</p> <p>1. Criteria used to determine when the monitoring may be stopped includes the following:</p> <p>D.O.N. will monitor the performance of each licensed nurse weekly. D.O.N. will discuss any deficient practices noted in the weekly departmental meetings.</p> <p>Consultant Pharmacy will monitor monthly during visit.</p> <p>D.O.N. and Consultant Pharmacy will discuss evaluations at Q.A. which will determine if ongoing monitoring is needed. The success will be measured by each nurse skills performance evaluation.</p>		

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure the environment was free of accident hazards related to leaving an open, unattended paint container in reach of a cognitively impaired, wandering resident for 1 of 1 residents reviewed for accidents. (Resident #18)</p> <p>Findings include:</p> <p>On 2/17/14 at 11:39 a.m., a paint pan and brush were on the floor at the end of the West hall. There was no staff present. At 11:43 a.m., Resident #18 was observed walking down the West hall near the paint. At 11:45 a.m., the Director of Nursing was heard calling to the resident to stay away from the paint. At 11:48 a.m., the resident walked down the West hall again near the paint. At 11:49 a.m., the Maintenance Man returned to the paint pan.</p> <p>On 2/17/14 at 1:49 p.m., the paint</p>	F000323	<p>F Tag 323 Free Of Accident Hazards/Supervision/Devices 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Outside contractor was immediately informed that no supplies used should be left unattended in the building. Potential dangers were discussed with outside contractor about working with the elderly and their cognitive ability. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other residents affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-service held with outside contractor, maintenance staff on resident safety while cleaning and maintain the building. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Maintenance Supervisor will monitor outside contractors and to ensure no items are left unsecure. Administrative Designee will</p>	03/22/2014	

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	<p>pan and brush were observed on a chair near the door of Resident #18's room. There was no staff present, the resident was observed in the hall outside her room. At 1:55 p.m., the Maintenance Man had returned to the room.</p> <p>The record for Resident #18 was reviewed on 2/18/14 at 2:00 p.m. The resident was admitted to the facility on 9/18/12.</p> <p>The February 2014 Physician Order Statement (POS) diagnoses included, but were not limited to, mental disorder and hepatic encephalopathy.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 1/2/14 indicated the resident had a BIMS (Brief Interview for Mental Status) score of 4, which indicated she was cognitively impaired.</p> <p>A care plan dated 1/2/14 indicated the resident was a wanderer. The care plan indicated, "She paces the hallways without purpose, and will enter empty rooms, or other resident rooms." Approaches included to redirect her and provide structured activities.</p>		<p>orientate new outside contractors about safety with the elderly. Administrator will monitor orientation of new outside contractors monthly times one month times 3 months then semi-annually Q.A. Committee will determine effectiveness of the orientation plan for outside contractor's times one month for 3 months then as needed. Policy will be reviewed annually 5. Completion Date: 3/22/13 UPDATE: 3/24/14</p> <p>1. Criteria used to determine when the monitoring may be stopped includes the following:</p> <p>The facility has a limited number of outside contractors which do work in the facility resident areas. When the contractors are in the resident care areas they will be informed of resident safety during their entrance and they will be monitored by the administrative designee daily until work is completed. This will be the ongoing system of practice when outside</p>		

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F000325 SS=D	<p>Interview with the Administrator on 2/20/14 at 3:45 p.m., indicated the paint should not have been left where the resident could have reached it.</p> <p>3.1-45(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review, and interview, the facility failed to ensure each resident maintained acceptable parameters of nutrition for those residents who were underweight with a low Body Mass Index (BMI) related to not</p>	F000325	<p>contractors are in the building during repairs. The effectiveness of the entrance orientation of outside contractors will be evaluated by Q.A. monthly for 3 months. QA committee will review outside contractor orientation quarterly and determine if changes need to be made or monitoring needs to continue. The success will be determined by number of deficient reports presented by administrative designee in weekly departmental meetings which will be discussed in QA meeting.</p> <p>F 325 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>	03/22/2014	

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	<p>receiving supplements as ordered for 2 of 3 residents reviewed for nutrition of the 3 residents who met the criteria for nutrition. (Residents #13 & #19)</p> <p>Findings include:</p> <p>1. On 2/18/14 at 12:40 p.m., Resident #19 was observed sitting at the table eating his lunch. The resident was served barbeque pork, sweet mashed potatoes, cabbage, and roll and butter. The resident was not served super mashed potatoes.</p> <p>On 2/19/14 at 7:45 a.m., the resident was observed sitting in a chair eating breakfast. He was served a bowl of oatmeal, toast, and an egg and sausage casserole with milk and coffee.</p> <p>Interview with the Dietary Cook on 2/19/14 at 7:50 a.m., indicated the super cereal was oatmeal with extra brown sugar added to it. He indicated he added about 4 tablespoons of brown sugar and nothing else. He indicated he did not follow a recipe.</p> <p>On 2/19/14 at 12:30 p.m., the resident was observed seated at the</p>		<p>Resident #13 & 19 Dietary Cards were reviewed and corrected and a super mashed potato was added to one card. Recipe for super mashed potatoes was reviewed with the cook and the necessity of following the orders on the tray cards and proper recipes.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>All 2 residents receiving super mashed potatoes were affected.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p>		

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	<p>table in the main dining room finishing his lunch meal. At that time, the resident was served french fries and not served super mashed potatoes.</p> <p>Interview with the Dietary Cook at the time, indicated the resident was not served super mashed potatoes. He indicated he followed the tray cards and on the resident's tray card super mashed potatoes was not listed. The Cook further indicated the resident had not been served the super mashed potatoes all week. Continued interview with the Cook, indicated he made the super mashed potatoes from scratch and added milk and 2 tablespoons of real butter. He indicated he did not follow a recipe and was not sure how much milk was added.</p> <p>The record for Resident #19 was reviewed on 2/18/14 at 11:36 a.m. The resident was admitted to the facility on 4/4/12. The resident's diagnoses included, but were not limited to, dementia, syphilis, hallucinations, insomnia, non compliance with medical treatment, and psychosis.</p> <p>Review of the 1/17/14 Quarterly Minimum Data Set (MDS)</p>		<p>The need for a new cook has been determined by administration but the entire nursing staff and dietary staff will be in-serviced on the importance of added nutritional benefits to the residents requiring items such as super mashed potatoes and super cereal. Recipes for super mashed potatoes and super cereal will be reviewed with both the dietary and nursing staff.</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <p>The F.S.S. and licensed nursing staff will be responsible for each ensuring each resident receives the required super mashed potatoes and super cereal daily while serving meal trays.</p>		

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	<p>Assessment indicated the resident was not alert and oriented. The resident needed limited assistance with eating with one person physical help. The resident had no weight loss and was 72 inches tall and weighed 138 pounds.</p> <p>Review of the Registered Dietitian (RD) Progress Notes dated 7/27/13 indicated the resident's weight for July was 134 pounds. The resident's weight for June was 141 pounds. The resident's Body Mass Index (BMI) was 18 (underweight status). The resident was observed during the noon meal. After few minutes he got up and went to his room. The resident eats 50% of meals. Recommend super cereal at breakfast and super mashed potatoes at lunch.</p> <p>Review of the 2/9/14 RD Progress Note indicated the resident's weight was 136 pounds and his current BMI was 18.5.</p> <p>Review of the annual Nutritional Assessment form completed by the RD dated 4/13/13 indicated the resident weighed 140 pounds and had a BMI of 19. The RD indicated the BMI was on the lower end.</p>		<p>The dietician will in-service the dietary department and require a return demonstration on the proper preparation of the super mashed potatoes and super cereal. She will monitor this process monthly for 2 months then quarterly thereafter.</p> <p>The D.O.N. will review recipe for super mashed potatoes and super cereal with the entire nursing staff and the importance of the resident receiving the required food items.</p> <p>Dietician and FSS will review diet tray cards monthly.</p> <p>FSS and D.O.N. will monitor dietician recommendations during each facility visit. This will be an ongoing practice.</p> <p>Administrative Designee will</p>				

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	<p>Review of the current plan of care dated 1/17/14 indicated there was no plan of care for the resident's underweight status with a low BMI of 18.</p> <p>Review of the current 2/2014 recap indicated the Physician's Order with the original date of 4/9/13 of regular diet with no added salt. Another Physician's Order dated 7/27/13 indicated super cereal at breakfast. Super mashed potatoes was ordered on 4/8/13.</p> <p>Review of the recipe for the super cereal provided by the Social Service Designee on 2/19/14 at 2:00 p.m., indicated the ingredients for four servings were as follows: 2 and 1/2 cups of dry oatmeal, 1/3 cup of 2% milk, 3 and 1/2 cups of water, 1 cup of nonfat dry milk, 1/4 pound of butter, 1/2 cup of brown sugar, and 1/2 cup of granulated sugar.</p> <p>Interview with the Social Service Designee on 2/19/14 at 2:00 p.m., indicated the Dietary Cook did not follow the recipe for the super cereal. She further indicated the resident's tray cards were just updated and changed, and he should have been receiving the super mashed potatoes.</p>		<p>monitor super mashed potatoes and super cereal 3 times a week for one month then monthly for 3 months then quarterly thereafter.</p> <p>Q.A. will monthly monitor the effectiveness of the administration of super mashed potatoes and super cereal as it relates to weight gain or weight stabilization.</p> <p>5.3/22/14</p>		

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	<p>2. The record for Resident #13 was reviewed on 2/19/14 at 1:05 p.m. The resident was admitted to the facility on 10/2/08. The resident's diagnoses on the February 2014 Physician Order Statement (POS) included, but were not limited to, Alzheimer's disease, depression and kidney disease.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 12/27/13, indicated the resident's cognitive skills were severely impaired. Her functional status indicated she required two person assistance for mobility and transfers, and was totally dependant for activities of daily living (ADL's), including feeding assistance.</p> <p>Review of the resident's monthly weights included as follows: February 2013- 115 pounds April 2013- 113 pounds May 2013- 105 pounds June 2013- 104 pounds July 2013- 101 pounds October 2013- 102 pounds December 2013- 99 pounds February 2014- 103 pounds</p> <p>A Dietary progress note dated 5/25/13 indicated a weight loss of 8 pounds from the previous month. A</p>	F000325	<p>F 325</p> <p>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #13 & 19 Dietary Cards were reviewed and corrected and a super mashed potato was added to one card. Recipe for super mashed potatoes was reviewed with the cook and the necessity of following the orders on the tray cards and proper recipes.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>All 2 residents receiving super mashed potatoes were affected.</p>	03/22/2014			

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	<p>recommendation was made for super cereal at breakfast every day. The Dietary note indicated the Physician ordered super cereal on 5/25/13.</p> <p>A Dietary progress note dated 6/4/13 indicated the resident was started on super mashed potatoes with lunch and dinner, and house supplement to help stabilize weight.</p> <p>Review of the February 2014 POS indicated the resident was to receive 1 can of house supplement daily due to weight loss.</p> <p>Interview with LPN #1 on 2/20/14 at 9:00 a.m., indicated the resident was not on a nutritional supplement.</p> <p>Review of the Medication and Treatment Administration Records for October, November and December 2013, and January and February 2014, did not indicate the resident received a house nutritional supplement as ordered.</p> <p>Interview with the Dietary Cook on 2/19/14 at 7:50 a.m., indicated the super cereal was oatmeal with extra brown sugar added to it. He indicated he added about 4 tablespoons of brown sugar and</p>		<p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>The need for a new cook has been determined by administration but the entire nursing staff and dietary staff will be in-serviced on the importance of added nutritional benefits to the residents requiring items such as super mashed potatoes and super cereal. Recipes for super mashed potatoes and super cereal will be reviewed with both the dietary and nursing staff.</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <p>The F.S.S. and licensed nursing staff will be responsible for each ensuring each resident receives the required super</p>				

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	<p>nothing else. He indicated he did not follow a recipe.</p> <p>Review of the recipe for the super cereal provided by the Social Service Designee on 2/20/14 at 2:00 p.m., indicated the ingredients for four servings were as follows: 2 and 1/2 cups of dry oatmeal, 1/3 cup of 2% milk, 3 and 1/2 cups of water, 1 cup of nonfat dry milk, 1/4 pound of butter, 1/2 cup of brown sugar, and 1/2 cup of granulated sugar.</p> <p>3.1-46(A)(2)</p>		<p>mashed potatoes and super cereal daily while serving meal trays.</p> <p>The dietician will in-service the dietary department and require a return demonstration on the proper preparation of the super mashed potatoes and super cereal. She will monitor this process monthly for 2 months then quarterly thereafter.</p> <p>The D.O.N. will review recipe for super mashed potatoes and super cereal with the entire nursing staff and the importance of the resident receiving the required food items.</p> <p>Dietician and FSS will review diet tray cards monthly.</p> <p>FSS and D.O.N. will monitor dietician recommendations</p>	

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			<p>during each facility visit. This will be an ongoing practice.</p> <p>Administrative Designee will monitor super mashed potatoes and super cereal 3 times a week for one month then monthly for 3 months then quarterly thereafter.</p> <p>Q.A. will monthly monitor the effectiveness of the administration of super mashed potatoes and super cereal as it relates to weight gain or weight stabilization.</p> <p>5.3/22/14</p>		

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 observation, record review, and interview, the facility failed to ensure each resident was free from unnecessary medications related to lack of indications for use of antipsychotic medication, lack of behavior monitoring, and lack of monitoring hypnotic medication for 4 of 6 residents reviewed for unnecessary medications. (Residents #6, #18, #19, and #20)</p> <p>Findings include:</p>	F000329	<p>F 329 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2/19/14 our original pharmacist consultant returned after being ill and the concerns over psychotropic medication was immediately addressed for Resident #6, 18, 19, 20.</p>	03/22/2014			

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	<p>1. On 2/18/14 at 11:03 a.m., Resident #6 was observed sitting in a geri chair in the main dining room. His eyes were closed and there were no behaviors noted.</p> <p>On 2/18/14 at 2:45 p.m. the resident was observed in his room in the geri chair. His eyes were closed and he not was exhibiting any behaviors.</p> <p>On 2/19/14 at 6:30 a.m., the resident was observed sitting up in a geri chair in the dining room. His eyes were closed and he was not exhibiting any behaviors.</p> <p>On 2/19/14 at 11:00 a.m., the resident was observed sitting in a reclined geri chair. His eyes were closed and he was not exhibiting any behaviors.</p> <p>The record for Resident #6 was reviewed on 2/19/14 at 1:30 p.m. The resident's diagnoses included but were not limited to, convulsions, epilepsy, blindness, impaired hearing, anxiety, mental retardation, altered mental status, agitation with behavior problems, and insomnia.</p> <p>Review of the Annual 1/12/14 Minimum Data Set (MDS)</p>		<p>Resident 6 Risperdal .5mg Bid reduced to 0.5mg q hs. Another attempt for dose reduction from 0.5mg to 0.25mg q hs will be tried.</p> <p>Resident 18 Ambien 5mg reduced to 2.5 mg</p> <p>Resident 19 Ambien reduced from 10mg to 5mg. Resident 20 diagnosis was updated to the following Haldol & Quetiapine new diagnosis indicates use of these meds are for psychosis due to Huntington's Disease.</p> <p>Diazepam diagnosis was updated and indicated use is for muscle spasms due to Huntington 's disease.</p> <p>Resident 19 has been seen by 2 psychiatrists in the past and family was not satisfied with their services.</p> <p>Resident 18 has been seen by a psychiatrist with no change in plan of care.</p> <p>Resident 6 has never seen a psychiatrist while in this</p>		

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	<p>Assessment indicated the resident was not alert and oriented and was severely impaired for decision making. The resident had behaviors of delirium that were continuously present related to inattention and disorganized thinking. He had an altered level of consciousness and his psychomotor behavior was present and fluctuated daily. The resident's mood status indicated he had little interest in doing things and trouble concentrating. The resident was also assessed as having physical behavioral, and verbal behavioral symptoms directed toward staff and others daily. The resident needed extensive assist with bed mobility and transfers with a one person physical assist. The resident was totally dependent on staff for dressing, grooming, and bathing.</p> <p>The resident was admitted to the hospital on 12/31/13 returned to the facility on 1/4/14. He was again admitted to the hospital on 2/9/14 and returned on 2/11/14 for syncope episodes.</p> <p>Review of Physician Orders dated 2/5/15 indicated Risperdone (an antipsychotic medication) .5 milligrams twice a day.</p>		<p>facility.</p> <p>Resident 20 has never seen a psychiatrist while in this facility.</p> <p>D.O.N. has made contact with Neuro Psychiatric Hospital in Mishawaka, Indiana to see if the facility will be able to provide psychiatric services for our residents.</p> <p>All licensed nurses were in-serviced on 2/17/14 & 2/18/14 and report given to surveryor.</p> <p>2 . How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken The medical director, pharmacist and charge nurse discussed all residents receiving psychotropic medications. No other</p>		

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	<p>Review of the Nursing Progress Notes for the months of November and December 2013 and for the months of January and February 2014 indicated there was no evidence of any documented behaviors of physical and verbal aggression.</p> <p>There was no evidence of any documented behavior sheets or behavior monitoring.</p> <p>There was no evidence of any documented indications for the use of the Risperdone medication.</p> <p>Interview with CNA #2 on 2/19/14 at 2:45 p.m., indicated the resident had not had any behaviors in the last month. She further indicated she had just been working at the facility for a month.</p> <p>Interview with CNA #1 on 2/19/14 at 2:50 p.m., indicated the resident had not had any behaviors in a long time. She indicated once in a while he would yell if his liquids had dripped on him. She further indicated the resident does not spit on the floor or yell and be rude to others anymore.</p>		<p>residents affected at this time.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Gradual dose reductions will be attempted 2 times in the first year of initial antipsychotic therapy q 6 months and annually thereafter.</p> <p>An Unnecessary Drug In-Service will be presented to nurses by D.O.N. The consultant pharmacist will review all of the physician orders for unnecessary drugs and will make recommendations as needed for dose reductions and discontinuation of unnecessary medication monthly. Psychoactive & Sedative/Hypnotic Utilization By Resident form will be completed by pharmacist consultant which indicates resident name, medication class, medication, dose and directions, next evaluation</p>	

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	<p>Interview with the Social Service Designee on 2/19/14 at 2:52 p.m., indicated the resident had not had any behaviors in a long time. She further indicated he does not do much yelling anymore.</p> <p>Interview with the Pharmacist Consultant on 2/19/14 at 12:35 p.m., indicated there was no supporting documentation or indication for the use of Risperdone. She further indicated it had looked as if he was readmitted back from the hospital with the medication and the facility just kept the medication.</p> <p>2. The record for Resident #19 was reviewed on 2/18/14 at 11:36 a.m. The resident was admitted to the facility on 4/4/12. The resident's diagnoses included, but were not limited to, dementia, syphilis, hallucinations, insomnia, non compliance with medical treatment, and psychosis.</p> <p>Review of the 1/17/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented. The resident needed limited assistance with eating with one person physical help. The resident received an antipsychotic and hypnotic</p>		<p>date and original order date and given to the D.O.N. for review.</p> <p>Medication reduction will be assessed quarterly for each resident.</p> <p>Pharmacist Consultant will schedule an in-service with licensed staff to review psychoactive medications TBA. D.O.N. is currently working on new psychiatrist that can service the residents of the facility.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur. Charge Nurse will indicate any behavior problems in the nurse recommendations columns for the physician to address in his progress note. Charge Nurse will monitor behavior log daily on each shift. The consultant pharmacist will review physician orders monthly Director of Nursing and or designee will review and audit physician orders for unnecessary medications weekly times 4 weeks then monthly for 3 months then every 6 months. QA will</p>				

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	<p>medication seven days a week.</p> <p>Review of Physician Orders on the current 2/2014 recap indicated Zolpidem (a hypnotic medication) 10 milligrams at night time. The original date for the order was 4/8/13.</p> <p>Review of Physician Orders dated 2/8/13 indicated Zolpidem 15 milligrams (mg) at night. The medication had been reduced to 10 milligrams on 4/8/13.</p> <p>Review of a Pharmacy Consultation report dated 11/22/13 indicated the resident was receiving the hypnotic agent Zolpidem 10 mg at night time. A dosage reduction should be attempted quarterly approximately every 3 months until the lowest effective dose was achieved or the medication was discontinued. The Physician had checked "No" and indicated "Needs present meds." No further information or explanation was documented by the Physician.</p> <p>Review of Physician Orders dated 11/4/13 indicated to make appointment with the psychiatrist (name) for an evaluation or an available psychiatrist in area.</p> <p>Review of Physician Progress Notes</p>		<p>review audits quarterly and make recommendation as needed and evaluate new psychiatric services once contract is secured. QA will meet monthly to discuss referral needs for psychiatric consults. 5. Date completed: 3/22/14</p>				

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	<p>for the months of November and December 2013 and January and February 2014 indicated there was no evidence the resident had been seen by the psychiatrist.</p> <p>Interview with the Director of Nursing on 2/18/14 at 4:00 p.m., indicated they had been having trouble getting a psychiatrist to see the residents at the facility. She further indicated a psychiatrist had not seen the resident. She indicated there had been no attempts to reduce the Zolpidem and there was no supporting documentation from the Physician regarding the pharmacy recommendation to continue the use of the hypnotic medication.</p> <p>3. The record for Resident #18 was reviewed on 2/18/14 at 2:00 p.m. The resident was admitted to the facility on 9/18/12. The February 2014 Physician Order Statement (POS) diagnoses included, but were not limited to, mental disorder and hepatic encephalopathy.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 1/2/14 indicated the resident had a BIMS (Brief Interview for Mental Status) score of 4, which indicated she was cognitively impaired.</p>						

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	<p>A Pharmacy review dated 12/31/13, indicated recommend decreasing Ambien from 10 mg (milligrams) at bedtime, to 5 mg at bedtime.</p> <p>A Physician order dated 1/16/14 indicated to discontinue Ambien 10 mg, and begin Ambien 5 mg at bedtime.</p> <p>The January 2014 Medication Administration Record (MAR), indicated Ambien 5 mg had been initiated on January 18. The February 2014 MAR did not include Ambien.</p> <p>Review of the January and February 2014 Physician Order Statement, did not include Ambien in the medications.</p> <p>Interview with the Director of Nursing (DoN) on 2/18/14 at 3:14 p.m., indicated she was unable to explain why the Ambien had not been documented. The medication cart was checked at that time and 2 Ambien 5 mg tablets were in the resident's medication tray. At 3:50 p.m., she contacted evening LPN #1 on the phone. The LPN indicated she had made a mistake and not carried the Ambien over when she did the monthly medication recap.</p>						

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	<p>She indicated she gave the resident the Ambien every night as ordered. She indicated she would come in that evening to correct the mistake. The DoN indicated she would re-educate and inservice the Nurses regarding medication administration and documentation.</p> <p>4. The record for Resident #20 was reviewed on 2/18/14 at 10:45 a.m. The resident was admitted on 7/18/12; his diagnoses included, but were not limited to, anxiety, Huntington's Chorea, hyper-sexuality, and agitation with aggressive behaviors.</p> <p>Review of the February 2014 Physician's Orders Summary (POS), indicated the resident was to receive Diazepam (an anti-anxiety medication) 10 milligrams (mg) by mouth daily and 5 mg by mouth at bedtime. Haldol (an anti-psychotic medication) 5 mg by mouth at bedtime, Remeron (an anti-depressant medication) 15 mg by mouth at bedtime, and Seroquel (an anti-psychotic medication) 600 mg by mouth at bedtime.</p> <p>The Plan of Care dated 9/20/12, indicated the problem of "I have</p>				

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	<p>agitation with aggressive behaviors." Further review also indicated the problem of "I have anxiety." The approaches included, but were not limited to, administer medications as prescribed.</p> <p>There was no evidence of documentation related to Pharmacy Recommendations related to Gradual Dose Reductions (GDR) since the resident's admission to the facility.</p> <p>Interview with the Director of Nursing (DoN) on 2/18/14 at 2:36 p.m., indicated there were no Pharmacy Recommendations related to the resident's psychotropic medications and the facility had not completed any GDR related to the resident's prescribed anti-anxiety, anti-depressant, and anti-psychotic medications. She also indicated the resident had not been evaluated by Psychiatry.</p> <p>3.1-48(b)(2)</p>				

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F000363 SS=E	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interview, the facility failed to ensure the menu was posted and followed related to serving pureed prunes, and following the recipe for super cereal and super mashed potatoes for 2 of 2 breakfast meals observed and for 2 of 2 lunch meals observed. This had the potential to effect 5 of 5 residents who received pureed diets.</p> <p>Findings include:</p> <p>1. Observation on 2/17/14 at 8:25 a.m., during the breakfast meal indicated none of the pureed diets received prunes on their meal trays. There were approximately five residents who did not receive pureed prunes.</p> <p>Further observation indicated the menu was not posted in or around the dining room prior to the breakfast meal.</p>	F000363	<p>F 363 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Menu was posted which is usually the responsibility of the FSS to post on Monday morning and do dietary inventory but FSS had an emergency. Recipe for super cereal and super mashed potatoes was reviewed with the cook. Recipe for pureed prunes was reviewed with cook. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficiencies noted.</p>	03/22/2014			

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	<p>Review of the menu provided by the Social Service Designee indicated the residents were to receive hot cereal, 1 ounce egg, and 1/2 cup cooked prunes for breakfast on 2/17/14</p> <p>Interview with the Administrator on 2/18/14 at 3:30 p.m., indicated the residents who eat pureed food should have received the prunes as well. She further indicated the Dietary Cook was new to the facility.</p> <p>2. On 2/17/14 at 8:25 a.m., and on 2/19/14 at 7:45 a.m., super cereal was served to four residents.</p> <p>Interview with the Dietary Cook on 2/19/14 at 7:50 a.m., indicated the super cereal was oatmeal with extra brown sugar added to it. He indicated he added about 4 tablespoons of brown sugar and nothing else. He indicated he did not follow a recipe.</p> <p>Review of the recipe for the super cereal provided by the Social Service Designee on 2/19/14 at 2:00 p.m., indicated the ingredients for four servings were as follows: 2 and 1/2 cups of dry oatmeal, 1/3 cup of 2% milk, 3 and 1/2 cups of water, 1 cup of nonfat dry milk, 1/4 pound of</p>		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>FSS will post 2 week menu cycle and menu must be served as posted.</p> <p>All menus were reviewed by the dietician and an in-service will be held by the dietician. Conference held with the FSS and changes in the dietary department are up coming. New dietary staff will be hired. It is a simple thing to read and take pride in what they are doing as part of the dietary staff.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur. Menu posting and menu served log will be used daily and monitored daily by administrator for 1 month then quarterly for 6 months. Menu served log will be monitored bi-weekly by the dietician. Ongoing in-services will continue to be done and reminders will be placed on the serve tray line. QA committee will review audits quarterly and determine of audits to continue or if changes need to be made.</p> <p>5. Date completed: 3/22/14</p>				

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	<p>butter, 1/2 cup of brown sugar, and 1/2 cup of granulated sugar.</p> <p>On 2/17/14 at 12:40 p.m., and on 2/19/14 at 12:30 p.m., super mashed potatoes were served to four residents.</p> <p>Interview with the Dietary Cook on 2/19/14 at 12:50 p.m., indicated he made the super mashed potatoes from scratch and added milk and 2 tablespoons of real butter. He indicated he did not follow a recipe and was not sure how much milk was added.</p> <p>Review of the super mashed potatoes recipe provided by the Social Service Designee on 2/19/14 at 2:00 p.m., indicated for five servings the recipe was as follows: 2 cups of instant mashed potatoes, 1 and 3/4 cups of milk or half and half, 2 tablespoons of butter, 2 tablespoons of sour cream (optional) and 1/4 teaspoon of salt (optional).</p> <p>Interview with the Administrator on 2/20/14 at 12:45 p.m., indicated the Dietary Cook was new in his position, but the recipes for the super cereal and super mashed potatoes should have been followed.</p>						

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F000365 SS=E	<p>3.1-20(i)(1) 3.1-20(i)(4)</p> <p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based observation, record review, and interview the facility failed to ensure food was prepared to meet individual needs related to not preparing pureed salad properly. This had the potential to affect 5 of the 5 residents who received a pureed diet</p> <p>Findings include: On 2/17/14 at 1:10 p.m., the Dietary Cook was observed pureeing salad. He placed lettuce into the food processor, he then pureed the lettuce, added water and pureed again. The lettuce and water were not measured. He then poured the mixture into five serving bowls from the food processor container without measuring. Interview with the Kitchen Employee at that time indicated there was a recipe. He retrieved the recipe book from another room and set it on the</p>	F000365	F 365 Food 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Recipe for pureed salad was reviewed with the cook. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficiencies noted. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.	03/22/2014			

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	<p>counter, he then continued with lunch preparation. He indicated he was not using a recipe.</p> <p>The menu for 2/17/14 indicated lunch was to include 1/2 cup salad with dressing.</p> <p>The recipe for pureed tossed salad was: 1.25 gallon tossed salad 200-12 gram dressing packets 1.33 cup #25 Thicken up Resource 1. Prepare Tossed Salad Recipe as directed. 2. Remove portions to be pureed from the regular prepared recipe. 3. Add to food processor and process until fine in consistency. 4. Add Thicken Up and salad dressing while preparing.</p> <p>3.1-21(a)(3)</p>		<p>The need for a new cook has been determined by administration. Recipe for pureed prunes will be reviewed with the dietary staff.</p> <p>Conference held with the FSS and changes in the dietary department are up coming. New dietary staff will be hired. It is a simple thing to read and take pride in what they are doing as part of the dietary staff.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <p>The F.S.S. responsible for monitoring residents receiving pureed diet weekly.</p> <p>Dietician will in-service the dietary department and require a return demonstration of proper preparation of pureed salad.</p> <p>Administrative Designee will monitor pureed meals 3 times</p>		

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			<p>a week for one month then monthly for 3 months then quarterly thereafter.</p> <p>Q.A. will monthly monitor the meal served logs and monitor proper food preparation for pureed diet. During Q.A. the dietician will express her concerns if the proper criteria for ensuring each resident receives their prescribed diet consisting of food prepared in the formed designed to meet their individual needs. At that time if no deficient practices are noted it will be determined to stop audits. If audits show a deficient practice still occurs then the audits will be increased and other dietary staff hired.</p> <p>5. 3/22/14</p>		

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F000368 SS=D	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on observation and interview, the facility failed to serve meals on time for 2 of 2 meals observed. This had the potential to affect 20 of 21 residents.</p> <p>Findings include:</p> <p>On 2/17/14 at 7:55 a.m., the breakfast meal was observed. At that time, staff were serving beverages to the seated residents. The first breakfast tray was served at 8:25 a.m. The last breakfast tray was served at 9:03 a.m.</p> <p>On 2/17/14 at 12:30 p.m., the lunch</p>	F000368	F 368	03/22/2014			
			<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The D.O.N. stated the wrong time. We changed the times in 2011 to a more relaxed meal time setting. The meal</p>				

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	<p>meal was observed. At that time, staff were serving beverages to the seated residents. The first lunch tray was served at 12:40 p.m.</p> <p>Interview with the Director of Nursing (DoN) on 2/17/14 at 9:30 a.m., indicated the facility's meal schedule was: Breakfast 7:30 a.m., Lunch 11:30 a.m., and Dinner 5:30 p.m.</p> <p>3.1-21(c)</p>		<p>time was changed to the following:</p> <p>Breakfast starts at 7:30 am with coffee, hot chocolate and water being served followed with prayer by the designated resident and continues until 9:30a.m.</p> <p>Breakfast Time: 7:30am-9:30a.m.</p> <p>Lunch starts at 11:30 am with beverage service followed with prayer by the designated resident and continues until 1:00p.m.</p> <p>Lunch Time: 11:30 am-1:00pm</p> <p>Dinner starts at 5:30pm with beverage service followed with prayer by designated resident and continues until 7:00p.m.</p> <p>Dinner Time: 5:30pm-7:00pm</p>		

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			<p>HS Snack Time is 8:00p.m. to 10:00p.m.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>No one affected.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. None we will continue with the current system. Meal times will be posted in the dining room.</p> <p>4.How the corrective action</p>		

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F000371 SS=F	<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, interview and record review, the facility failed to ensure a sanitary kitchen related to lack of monitoring food temperatures, lack of monitoring dishwasher and sanitation bucket pH, and preparing sanitation bucket solution incorrectly. This had the potential to affect 20 of the 21 resident's in the facility who received meals prepared in the kitchen.</p> <p>Findings include:</p>	F000371	<p>will be monitored to ensure the deficient practice will not recur.</p> <p>Administrative/Administrative Designee will monitor mealtime weekly.QA will continue to monitor meal time semi-annually.</p> <p>5.Date completed: 2011</p> <p>F 371 FOOD SANITATION</p> <p>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>FSS reviewed the following policies regarding food sanitation. Areas include but not limited to food preparation temperatures in</p>	03/22/2014

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	<p>1. On 2/19/14 at 10:00 a.m., an observation was made of the sanitation bucket being prepared in the kitchen. The Dietary Cook used a small green pail, not labeled in size, approximately 1 gallon and filled it half full with warm water. The water temperature was not taken. He then removed the cap from a bottle of bleach, poured a capful of bleach and added it to the bucket. He indicated there were strips to test the pH of the solution, but did not know where they were. He was unable to locate the log where the pH results were supposed to be entered.</p> <p>A sign posted above the sink had instructions for, "Sanitation Bucket Bleach System". The sign read, "1 1/2 gallon of water 75-80 degrees, 1/2 teaspoon of bleach = 100 ppm."</p> <p>The policy titled, "Food Borne Illness", was received from the Social Service Designee on 2/20/14 at 3:00 p.m. The policy indicated that cross contamination of food was prevented by. "...Sanitizing solutions will be made correctly and used properly."</p> <p>2. Interview with the Dietary Cook on 2/17/14 at 8:30 a.m., indicated he</p>		<p>regards to the 4 hour rule Danger Zone 41 degrees -135 degrees, Temperature of cold foods maximum of 41F, hot foods minimum of 140F, food temperature logs, temperature test strips for dish machine and sanitization bucket.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficient practices relative to food sanitation noted.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Dietician will provide In-services on policies regarding food sanitation. Areas include but not limited to food preparation temperatures in regards to</p>				

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	<p>had forgotten to take the temperatures of the breakfast foods prior to serving. He indicated he knew the food temperatures needed to be taken prior to serving at each meal.</p> <p>Further interview with the Dietary Cook on 2/19/14 at 10:00 a.m., indicated he had two Food Service Worksheets which were for the temperature logs, one dated 2/19/14 and the other dated 2/18/14. He indicated the rest of the temperature logs were on a clipboard. Review of the clipboard revealed no additional temperature logs. He indicated he did not know where they were kept. The Food Service Worksheet dated 2/18/14 indicated the grits were 159 degrees and super cereal was 158 degrees. There was no temperature recorded for barbeque pork, whipped sweet potatoes, cabbage, onion and tomato salad, bread pudding or ice tea. These items were check marked, "Items at Appropriate Temperature". The Food Service Worksheet dated 2/19/14 had oatmeal and super cereal check marked, "Items at Appropriate Temperature", no temperature was recorded.</p> <p>A copy of the policy titled, "Food</p>		<p>the 4 hour rule Danger Zone 41 degrees -135 degrees, Temperature of cold foods maximum of 41F, hot foods minimum of 140F, food temperature logs, temperature test strips for dish machine and sanitization bucket.</p> <p>Administrative decision to hire new dietary staff because all previous areas were reviewed with cook.</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur. All sanitation rules and monitored by the dietician. FSS will monitor temperature logs and sanitation logs daily. Administrator will monitor all dietary log sheets times 2 months then quarterly for 6 months. QA committee will review log audits quarterly and determine of audits to continue or if changes need to be made. After all deficient practices have been resolved</p>		

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	<p>Borne Illness", was received from the Social Service Designee on 2/20/13 at 3:00 p.m. The policy indicated, "Keeping food at the correct temperature will greatly reduce the incidence of food borne illness. Always use a calibrated thermometer when taking temperatures and record your temperature."</p> <p>3. Observation on 2/19/14 at 10:00 a.m., indicated the kitchen had a low temperature automatic dishwasher, which used chemical sanitizing solution.</p> <p>Interview with the Dietary Cook, at that time, indicated he did not monitor the pH or do any type of maintenance to the dishwasher, he did not know where the maintenance logs were at. He indicated that was the responsibility of the Maintenance Supervisor.</p> <p>Interview with Maintenance Supervisor on 2/19/14 at 11:50 a.m., indicated he did not monitor the pH of the dishwasher, that was the responsibility of the kitchen staff.</p> <p>The policy titled, "Sanitation Procedure", was received from the Social Service Designee on 2/20/14</p>		<p>Q.A. committee meetings will resume to being quarterly however we reserve the right to meet more frequently if needed.</p> <p>5.Date completed: 3/22/14</p>				

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	<p>at 3:00 p.m. The policy indicated, "A minimum of bi-monthly Executive Housekeeper/ Food Service Supervisor/ R.D. Consultant will check the chlorine of the sanitizing solution."</p> <p>3.1-21(i)(3)</p>			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility</p>	F000441	F 441 INFECTION CONTROL	03/22/2014			

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	<p>failed to ensure an infection control program was maintained related to hand washing after glove removal, toothbrushes and urine containers uncovered, and the handling of needles after usage for 2 of 2 licensed staff observed during medication pass and for 2 of 6 residents observed during medication pass. (Resident #7 and #11) The facility also failed to ensure toothbrushes and urine collections containers were covered on 2 or 2 Units. (The East and West Unit)</p> <p>Findings include:</p> <p>1. On 2/18/14 at 9:25 a.m., RN #1 was observed preparing to administer eye drops to Resident #7. RN #1 walked into the resident's room and donned a pair of clean gloves. She then placed one drop into each eye. She was observed to wipe the resident's eyes with the tissue as they were watery from the eye medication. The RN left the room with the gloves on her hands and opened the medication cart and placed the eye drops back into the cart. She was observed to remove her gloves and held them in her hands. Another resident was near and was getting ready to leave so</p>		<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? LPN was provided with Blood Glucose Monitoring System procedure manual. A review of the Disinfecting Guidelines was discussed and she was able to perform the proper mixture of disinfecting solution and clean the accu-check machine after each use.</p> <p>All licensed nurses instructed to take medication cart with them because sharp containers are located on the side of each cart.</p> <p>Handwashing Policy was reviewed with LPN and RN and reminders given to be attached to name tag.</p> <p>Toothbrushes were thrown away.</p> <p>Urine Collection Containers were removed and C.N.A. instructed to keep urine collection covered.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>No other residents were noted to be deficient.</p>		

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	<p>RN #1 helped the resident put on his jacket. The nurse walked back into the resident's room, disposed the gloves, and washed her hands with soap and water.</p> <p>Review of the current and undated hand washing policy provided by the Director of Nursing on 2/10/14 at 11:30 a.m., indicated indications for anti bacterial soap and water hand hygiene was for after glove removal.</p> <p>Interview with the Director of Nursing on 2/20/14 at 10:55 a.m., indicated the nurse should have washed her hands after removing her gloves.</p> <p>2. On 2/19/14 at 6:42 a.m. LPN #2 was observed preparing to do an Accucheck for Resident #11. He then donned clean gloves to both of his hands, grabbed the lancet, a test strip, and the test machine and walked into the resident's room. The LPN removed the cap from the lancet and pricked the resident's finger, obtained the blood, and placed the strip into the Accucheck machine. After he was finished he recapped the lancet and placed it into the sharps container on the side of the medication cart.</p> <p>Interview with the Director of Nursing</p>		<p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>An In-Service on Disinfecting Guidelines for Accu-Check machine, Hand washing, Proper Disposal of needles and lancets.</p> <p>All new hires for licensed nurse positions are required to perform a skills test on performing an Accu-Check was given to licensed nurses followed by return demonstration.</p> <p>A copy of the policy was given to each licensed nurse.</p> <p>Infection Control Policy reviewed with licensed staff and C.N.A.'s and each is required to wear hand washing policy with name tags, bed pans & urine collection containers are required to be covered and toothbrushes are required to be in toothbrush holders or covers.</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur. All new hires for licensed nurse positions are required to perform a skills test on performing an Accu-Check. Policy was given to licensed nurses followed by return demonstration.</p>				

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	<p>on 2/20/14 at 10:55 a.m., indicated the nurse should not have recapped the used the lancet.</p> <p>3. On 2/19/14 9:20 a.m., RN #1 was observed preparing Insulin for Resident #11. After she had drawn up the Insulin she walked down the hallway to the resident's room. She entered her room, placed clean gloves on both of her hands and administered the Insulin into her abdomen. The RN then left the room with her gloved hands and the uncapped needle and walked down the hall. The uncapped needle was still in her hand. She placed the needle into the sharps container which was located on the side of the medication cart. The RN removed her gloves and used alcohol gel to both of her hands.</p> <p>Interview with RN #1 at that time, indicated she should have brought her medication cart to the room, because there were no sharps containers in the resident's rooms.</p> <p>Review of the current and undated syringe sharp and needle disposal provided by the Director of Nursing on 2/20/14 at 11:30 a.m., indicated all needles were not be to recapped. They were to be placed in the</p>		<p>Skills testing will be performed on all employed licensed nurses and semi-annually thereafter.</p> <p>Monitoring for infection control will be added to nurse rounds sheet which will include toothbrushes properly stored, urine collection container covered.</p> <p>D.O.N. will monitor proper accu-check and use of sharp containers for need disposal 3 times a week for one week then monthly for 1 month then q six months.</p> <p>Q.A. committee will review D.O.N. reports on infection control and monitor skills testing on Accu-checks, insulin administration, and nurse rounds logs. Audits will be done quarterly and determine of audits to continue or if changes need to be made.</p> <p>5. Date completed: 3/22/14</p>				

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	<p>contaminated needle biohazard container located on the side of the medication cart.</p> <p>Interview with the Director of Nursing on 2/20/14 at 10:55 a.m., indicated the RN should not have walked down hallway with an uncapped needle.</p> <p>4. During the Environmental Tour on 2/20/14 at 8:55 a.m., with the Maintenance Director the following was observed:</p> <p>East:</p> <p>a. Two toothbrushes were on the sink uncovered in room 103. Two residents resided in this room.</p> <p>West:</p> <p>a. Two urine collection containers were on the floor uncovered next to the toilet in room 102. Two residents resided in this room.</p> <p>Interview with the Maintenance Director at that time, indicated the above areas were taken care of by the Nursing staff.</p> <p>3.1-18(b)(1)</p>				

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F000465 SS=E	<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. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to strong urine odors, dirty wheelchairs and geri-chairs, dirty bed rails and frames, chipped paint on the hallway handrails, marred walls and doors, stained window curtains, absence of light coverings, loose light fixtures, cracked and dirty seizure protectors, rusted toilet seats and side rails on 2 of 2 units throughout the facility. (The East and West Units)</p> <p>Findings include:</p> <p>During the Environmental Tour on 2/20/14 at 8:55 a.m., with the Maintenance Director the following was observed:</p> <p>East:</p> <p>a. The resident's geri-chair was dirty and soiled with dried food and</p>	F000465	<p>F 253 HOUSEKEEPING/MAINTANENCE</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All geri-chairs and wheelchairs were cleaned.</p> <p>Curtain Valence in room 103 & 120 were removed.</p> <p>The problem with the reoccurring urine odor in bathrooms 101, 107 & 109 and in room 109.</p> <p>The facility has contacted a new vendor for new products to attack the urine odor. In the past we have replaced the tile floor but the residents</p>	03/22/2014			

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	<p>beverages in room 113. Two residents resided in this room.</p> <p>b. The curtains were stained with dried paint in room 103. Two residents resided in this room.</p> <p>c. The resident's wheelchair was dirty and soiled with dried food and beverages. There was an odor of urine in the bathroom. The bathroom door and the walls were marred, and the toilet seat and side rails on both beds were rusty in room 105. Two residents resided in this room.</p> <p>d. The resident's wheelchair was dirty and soiled with dried food and beverages. There was also an odor of urine in the bathroom in room 107. Two residents resided in this room.</p> <p>e. There was an odor of urine in the resident's bedroom and bathroom in room 109. One resident resided in this room.</p> <p>f. There was an odor of urine in the bathroom and the bathroom door was marred in room 101. Two residents resided in this room.</p> <p>West:</p>		<p>that reside in the room urinate around the toilet and on the walls in rooms 101 & 107 & 109. Resident in room 109 urinates all over the room and in the radiator. The staff mops and cleans these problem areas throughout the day and monitored for the odor every 2 hours. We are continuing to look for an effective product but an outside contractor has been hired to remove the drywall in the bathrooms and then remove and replace the tile in the problem bathrooms and rooms. A covering will be placed over the drywall so that it will not absorb the urine</p> <p>Side rail and bed will be painted in room 105.</p> <p>All bathroom doors throughout facility have recently been painted, 101 bathroom door was touched up.</p> <p>All beds throughout the facility were general cleaned</p>				

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	<p>a. There was no covering on the light fixture located over the sink in room 102. Two residents resided in this room.</p> <p>b. The side bolsters (seizure protectors) were cracked along the entire top edge. The bed rails and bed frames were dirty. There was a brown substance on the garage can (no bag), and the light fixture above sink was hanging loose from the wall in room 104. One resident resided in this room.</p> <p>c. There was a brown substance on the lower frame of the bathroom door and the curtains were stained with dried paint in room 120. Two residents resided in this room.</p> <p>Interview with the Maintenance Director at the time, indicated the above areas were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>		<p>and painted outside in the Fall and scheduled again in the Spring which is part of our preventive maintenance program.</p> <p>Covers were applied to light fixtures in room 102. Light Fixture was tightened in room 104</p> <p>Side bolsters were replaced.</p> <p>The bed rails and bed frames was cleaned.</p> <p>Garage can was cleaned and bag inserted.</p> <p>Bathroom door cleaned.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other areas addressed.</p> <p>3. What measures will be put into place or what systemic changes will be made to</p>				

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			<p>ensure that the deficient practice does not recur. In-services on preventative maintenance and daily log sheets will be held by Administrator/Administrative Designee who will monitor that all deficient areas have been addressed and repairs completed. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. will be responsible in monitoring logs of nurse rounds for infection control and urine odors. Maintenance/Custodian Supervisor will monitor weekly for repairs and preventative maintenance log. The Administrator/Administrative Designee will monitor building for repairs and audit log sheets and preventative log monthly x 2 months then quarterly for next 6 months QA committee will review preventative maintenance logs and repair logs monthly then quarterly thereafter but reserve the right to meet</p>	

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F000520 SS=E	<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 record review and interview, the facility failed to identify non-compliance for daily activities involving the residents and ensuring gradual does reductions were completed for residents on psychotropic medications through the quality assurance protocol.</p>	F000520	<p>more often has plans are developed and implemented.</p> <p>5. 3/22/14</p> <p>F 520</p> <p>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>	03/22/2014			

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	<p>Findings include:</p> <p>Interview with the Administrator on 2/20/14 at 12:56 p.m., indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Director of Nursing (DoN), and department heads as well as the Medical Director. The Administrator indicated at the time, gradual dose reductions had not been discussed, addressed or identified as being a problem in Quality Assurance. She further indicated there had been no action plan or system put into place to identify the problem for the need to reduce the psychotropic medication.</p> <p>Continued interview with the Administrator at that time, indicated the way she used to monitor the psychotropic medications was by comparing the medications and the diagnoses from the Medication Administration Record (MAR) and the Physician Order Sheet every month, however, she does not think this was being done thoroughly.</p> <p>Interview with the Director of Nursing on 2/18/14 at 4:00 p.m., indicated they had been having trouble getting</p>		<p>The D.O.N. had addressed this problem in our weekly nurses meeting. This was scheduled to be discussed in our next Q.A. meeting to be held on Wednesday 2/19/14. This Q.A. meeting had to be rescheduled due to death. The facility has employed new nursing staff consisting of C.N.A's, R.N. and L.P.N's which have not been employed over 2 months. We have covered a lot of areas including introduction to new computer system but due to severe weather we have not been able to make the progress that we wanted. In January QA meetings had to be cancelled due to the snow. On 2/19/14 GDR was discussed with the pharmacist consultant and medical director with surveyor and all concerns were addressed and medication dose reductions were completed. Contact was also made to get a psychiatrist whom would be beneficial to the resident. The facility has discussed with the pharmacist consultant psychoactive and sedative monitoring in which quarterly reports are available. Even though the facility does not have a psychiatrist that met our standards we do monitor our residents on psychotropic and hypnotics. Resident 6 had been discussed with his</p>	

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	<p>a psychiatrist to see the residents at the facility. She further indicated she had thought the Pharmacy Consult was taking care of the gradual dose reductions.</p> <p>Interview with the Administrator on 2/20/14 at 12:56 p.m., indicated she was aware the facility needed to hire a new activity director and was in pursuance of that, however, she tried looking within the facility and could not find anyone. She further indicated they were actively looking for someone to take over as the Activity Director.</p> <p>Interview on 2/18/14 at 2:20 p.m., with the Social Service Designee (SSD) indicated there was no activity book with the resident's participation available at this time. She further indicated she thought the CNAs were responsible for completing and filling out the activity participation records for the residents.</p> <p>Interview with the Administrator on 2/18/14 at 3:15 p.m., indicated the Activity Director had not been at the facility on a full time basis during the day. She further indicated there was no documentation for the participation of residents including one to one visits as well as group</p>		<p>physician for a dose reduction but physician at that time would not agree to the reduction. The facility does agree that having a psychiatrist to monitor the psychoactive and sedative medications for dose reductions and avenues for new medications to try for residents exhibiting behaviors along with our old pharmacist consultant will be provide better monitoring for residents GDR.</p> <p>Clarification is needed the nursing staff and D.O.N. meet weekly and discuss our residents with behavior problems, weight problems, infections... We sometimes have a problem getting the physician to take our suggestions but with the psychiatrist service this should greatly improve our effort to ensure the resident receives the most effective medication for their behavior problem.</p>		

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	<p>participation records.</p> <p>The Activity Director was not available during the survey (2/17-2/20/14) for interview.</p> <p>3.1-52(a)(2)</p>		<p>Administrator has addressed the need for activity director.</p> <p>D.O.N. had scheduled to cover the needs of activities at our next nursing department staff meeting and explain the activity participation log sheets since the C.N.A. staff is new. D.O.N. had not addressed the activity procedure with the new staff.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>All residents are affected by the activity program and residents on psychoactive medications.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Pharmacy consultant will provide D.O.N. with monthly Psychoactive and Sedative/Hypnotic utilization</p>		

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			<p>Trends Log which indicates Class of Medication and # of residents receiving different types of psychoactive medications.</p> <p>Pharmacist consultant will provide D.O.N. and Psychoactive and Sedative Utilization By Resident Report so that the gradual dose reduction calendar is determined this will be shared with the Q.A. committee.</p> <p>Administrator will advertise for a full time Activity Director in the newspaper. Staff will be trained by the D.O.N. about activity calendar and resident activity participation sheets. Current Activity Director will be required to document quarterly progress notes and participate in care conferences until relieved of the required duties.</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur.</p> <p>Administrator will be responsible in monitoring Activity Director and reviewing her reports weekly.</p> <p>D.O.N. will be responsible in pursuing the new psychiatric services and working with the consultant pharmacy on GDR for residents monthly.</p>		

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			<p>QA will evaluate activities program and psychiatric services as it relates to GDR monthly then quarterly thereafter but reserve the right to meet more often has plans are developed and implemented.</p> <p>5.Date completed: 3/22/14</p>	