

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00169730.</p> <p>Complaint IN00169730-Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F465.</p> <p>Survey dates: May 12, 13, 14, 15, 18, and 19, 2015</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 21 Medicaid: 50 Other: 21 Total: 92</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 159 SS=E Bldg. 00	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to ensure residents had access to their money on the weekends and quarterly statements were given to the resident for 4 of 4 residents reviewed for personal funds of the 4 who met the criteria for personal funds. (Residents #5, #9, #27, &, #35)</p> <p>Findings include:</p> <p>1. Interview with Resident #9 on 5/13/15 at 9:31 a.m., indicated he was not able to get any money from his personal funds account on the weekends. He further indicated the last time he asked someone to go downstairs and find out how much money was in his account, the Business Office would not tell that person or give the statement to him.</p> <p>Review of Resident #9's personal funds account with the Regional Business Office Manager on 5/18/15 at 2:30 p.m., indicated she was just filling in at the facility due to the old Business Office Manager had left the position last week.</p>	F 159	<p>F159</p> <p>The facility requestspaper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Personal Funds statement was provided to Resident #5, 9, 27 and 35 and/or responsible party.</p> <p>2) How the facility identified other residents:</p>	06/12/2015

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	<p>She indicated the facility was able to print off two copies of the bank statement and send one to the resident's responsible party and give the other one to the resident. She indicated the system would not be able to show her if the pervious Manager had printed off more than one copy and had given it to the resident. She further indicated she was not sure if the resident had received a statement or not.</p> <p>Interview with the Director of Nursing on 5/19/15 at 11:11 a.m. indicated the old Business Office Manager who left the facility on Friday, 5/15/15 had not been very cooperative with the facility since she had left. She indicated from what she understood the old manager had gone up there to give the resident a check for money he had requested but was not sure she had gone over his quarterly statement with the him.</p> <p>2. Interview with Resident #27 on 5/13/15 at 11:31 a.m., indicated she was unable to get money from her personal funds account on the weekends.</p> <p>Interview with Resident #5 on 5/12/15 at 11:17 a.m., indicated she was unable to get any money from her personal funds account on the weekends.</p> <p>Interview with Resident #35 on 5/12/15</p>		<p>An audit was completed to identify other residents that wish to receive a copy of quarterly statements.</p> <p>3) Measures put into place/ System changes:</p> <p>An audit will be done quarterly to ensure that quarterly statements are provided to all residents and/or responsible parties as requested.</p> <p>The Executive Director will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: June 12, 2015</p>	

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F 164 SS=E	<p>at 10:58 a.m., indicated she was not able to get any money from her personal funds account on the weekends.</p> <p>Interview with the Administrator on 5/18/15 at 1:45 p.m., indicated there was no sign posted anywhere in the facility with the banking hours. He further indicated the residents were able to get money out of their funds during the weekend and it really all depended on when the receptionist was working, there were no set hours. He indicated he was unaware if the residents knew this or not. He further indicated there was a receptionist at the desk from 9:00 a.m., to 9:00 p.m., Monday through Friday and again he was not sure if the residents knew this or not.</p> <p>Interview with the Regional Business Office Manager on 5/18/15 at 2:30 p.m., indicated all of the above residents had a personal funds account with the facility. She further indicated the facility should have a system so that residents could have access to the their funds on the weekends.</p> <p>3.1-6(f)(1) 3.1-6(g)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY</p>				

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Bldg. 00	<p>OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the residents' privacy was maintained during medication pass for 5 of 7 residents observed during medication pass. (Residents #24, #38, #72, #77 & #92)</p> <p>Findings include: 1. On 5/15/15 at 7:45 a.m., LPN #4 was observed preparing medications for</p>	F 164	<p>F164</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute</i></p>	06/12/2015			

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	<p>Resident #24. The resident's medications were observed in white plastic wrappers which were provided by the pharmacy. On the outside of each wrapper was the resident's name, medication, and the dosage all listed in black lettering. LPN #4 then removed the pills from the wrappers and placed the empty wrappers in a clear plastic cylinder located on the top of the cart. The resident's private information on those wrappers was viewable from the cylinder.</p> <p>2. On 5/15/15 at 7:51 a.m., LPN #4 was observed preparing medications for Resident #92. The resident's medications were observed in white plastic wrappers which were provided by the pharmacy. On the outside of each wrapper was the resident's name, medication, and the dosage all listed in black lettering. LPN #4 then removed the pills from the wrappers and placed the empty wrappers in a clear plastic cylinder located on the top of the cart. The resident's private information on those wrappers was viewable from the cylinder.</p> <p>3. . On 5/15/15 at 7:59 a.m., LPN #4 was observed preparing medications for Resident #38. The resident's medications were observed in white plastic wrappers which were provided by the pharmacy. On the outside of each wrapper was the</p>		<p><i>admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: The clear canisters on the medication carts for residents 24, 38, 72, 77, and 92 were replaced with solid containers to hold the medication packaging.</p> <p>2) How the facility identified other residents:</p> <p>All residents that have medications in packaging had the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Clear canisters have been replaced with solid canisters. Licensed staff and QMAs have been in-serviced on maintaining privacy during medication administration. Random audits will be done 5 times per week at varied times to ensure compliance. Any discrepancies will be addressed as appropriate with re-education/disciplinary action. Director of Nursing or designee will be responsible for the</p>	

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	<p>resident's name, medication, and the dosage all listed in black lettering. LPN #4 then removed the pills from the wrappers and placed the empty wrappers in a clear plastic cylinder located on the top of the cart. The resident's private information on those wrappers was viewable from the cylinder.</p> <p>Interview with LPN #4 on 5/15/15 at 8:26 a.m., indicated she should have protected the residents' privacy by placing the plastic cylinder containing the wrappers in a drawer of the locked medication cart.</p> <p>4. On 5/15/15 at 8:07 a.m., LPN #1 was observed preparing medications for Resident #72. The resident's medications were observed in white plastic wrappers which were provided by the pharmacy. On the outside of each wrapper was the resident's name, medication, and the dosage all listed in black lettering. LPN #1 then removed the pills from the wrappers and placed them in a clear plastic cylinder located on the top of the cart. The resident's private information on those wrappers was viewable from the cylinder.</p> <p>5. On 5/15/15 at 8:13 a.m., LPN #1 was observed preparing medications for Resident #77. The resident's medications</p>		<p>oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: June 12, 2015</p>	

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F 247 SS=D Bldg. 00	<p>were observed in white plastic wrappers which were provided by the pharmacy. On the outside of each wrapper was the resident's name, medication, and the dosage all listed in black lettering. LPN #1 then removed the pills from the wrappers and placed the empty wrappers in a clear plastic cylinder located on the top of the cart. The resident's private information on those wrappers was viewable from the cylinder.</p> <p>Interview with LPN #1 on 5/15/15 at 8:07 a.m., indicated she should have protected the residents' privacy by placing the plastic cylinder containing the wrappers in a drawer of the locked medication cart or by placing the wrappers in a cylinder that was not clear.</p> <p>3.1-3(o)(3)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview, the facility failed to ensure a resident was notified of a new roommate for 1 of 3 residents reviewed for Admission, Transfer, and Discharge of the 3 residents who met the criteria for Admission, Transfer, and Discharge. (Resident #27)</p>	F 247	<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of</i></p>	06/12/2015			

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	<p>Finding includes:</p> <p>Interview with the Social Service Director on 5/18/15 at 3:07 p.m., indicated Resident #27 received a new roommate on 3/12/15 during the evening shift.</p> <p>The record for Resident #27 was reviewed at that time.</p> <p>Nursing Progress Notes and Social Service Progress Notes for 3/12/15 indicated documentation was lacking of any notification to the resident regarding her new roommate.</p> <p>Interview with the Social Service Director on 5/18/15 at 3:07 p.m., indicated the resident had not been given notice of the new roommate. She further indicated the facility's protocol was to notify the resident before the new roommate arrived.</p> <p>3.1-5(b)(1)</p>		<p><i>compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #27 was made aware of change in roommate.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed of all admissions and room changes in the last 30 days to identify any other residents affected and to ensure proper notifications were completed and documented.</p> <p>3) Measures put into place/ System changes:</p> <p>Facility protocol for roommate notification and documentation was reviewed with Social Service Director and Social Service Designee.</p> <p>An audit will be completed weekly of all admissions and room changes to ensure roommate was notified and</p>		

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F 323 SS=D Bldg. 00	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, record review, and interview, the facility failed to ensure a resident was free from accidents related to being left unattended in the dining room while the floor was wet for a resident with a history of falls for 1 of 5 residents reviewed for accidents of the 8 residents who met the criteria for accidents. (Resident #C) Finding includes:	F 323	documentation completed. The administrator will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: June 12, 2015 The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the</i>	06/12/2015

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	<p>On 5/15/15 at 5:20 a.m., there were 5 residents observed seated in their wheelchairs in the Linden Dining Room. The Linden Dining Room was located on the Special Care Unit. At 5:25 a.m., Housekeeper #1 was observed to come up to the unit and walk into the dining room where the residents were sitting.</p> <p>Interview with Housekeeper #1 at 5:27 a.m., indicated she usually worked the day shift. She indicated years ago the evening shift CNAS cleaned all of the dining rooms after the evening meal on the Special Care Unit. The Housekeeper indicated when the facility got a new Supervisor all of that changed and now the Laundry Aide on the evening shift was supposed to do it, however, she thought the Laundry Aide only cleaned the Pines Dining Room upstairs and nothing on the Special Care Unit. The Housekeeper indicated the 3-11 CNAS sweep up the floor and wipe off the tables and the midnight CNAS mop the floor in all of the Special Care Unit Dining Rooms. She then indicated she was going to sweep the floor now and touch it up a little that was why she was up there on the Linden Unit.</p> <p>At that time, Housekeeper #1 proceeded to sweep the dining room floor where the</p>		<p><i>provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #C was removed from the dining room without incident.</p> <p>2) How the facility identified other residents:</p> <p>The remaining residents had been removed from the dining room following notification of occurrence.</p> <p>3) Measures put into place/ System changes:</p> <p>Housekeeping and Nursing staff were re-educated regarding hazards and supervision to ensure all residents are removed prior to mopping of dining room.</p> <p>Random observation rounds will be completed after varied meals at least 3 times per week to ensure residents are not left in dining room unattended while floors are mopped.</p> <p>The Housekeeping supervisor will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will</p>	

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	<p>5 residents were seated in their wheelchairs. Resident #C was one of the 5 residents. She was observed sitting in her wheelchair by a table in the dining room. After the Housekeeper was done sweeping the floor, she grabbed her mop and started to mop the floor while the residents were in the dining room and seated in their wheelchairs. Both of the dining room doors were open and the residents remained in the dining room as she mopped. The Housekeeper mopped the right side of the dining room first and in between the tables where 3 of the residents were sitting. She then proceeded to the left side of the dining room and moved 2 of the residents out of the way to the middle of the room where the floor was now wet. She finished mopping and left the room to put her cart away in the closet. All five residents including Resident #C were left unattended in the room while the floor was wet.</p> <p>Interview with the Administrator on 5/15/15 at 1:30 p.m. indicated he was unaware there were residents in the dining room while the housekeeper was mopping the floor. He indicated the housekeeper should have removed the residents first then mopped the floor.</p> <p>The record for Resident #C was reviewed</p>		<p>be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: June 12, 2015</p>	
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	<p>on 5/19/15 at 9:14 a.m. The resident was newly admitted to the facility on 2/20/15. The resident's diagnoses included, but were not limited to, rehab, muscle weakness, cognitive communication, lack of coordination, and senile dementia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 5/5/15 indicated the the resident's Brief Interview for Mental Status was a 3 which indicated the resident was not alert and oriented. The resident needed extensive assist with a 2 person physical assist with transfers and the resident was able to walk in the corridor with a one person physical assist. The resident had 1 fall since the last assessment with no injury</p> <p>A fall assessment dated 3/4/15 indicated the resident was at risk for falls with a score of 10.</p> <p>A fall assessment dated 5/11/15 indicated the resident was at risk for falls with a score of 12. Another fall assessment dated 5/15/15 indicated the resident was at risk for falls with a score of 14.</p> <p>Interview with the Evening Shift Supervisor on 5/18/15 at 2:10 p.m., indicated the scores did not mean anything except the resident was at risk for falls.</p>			

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	<p>The 4/27/15 occurrence report was reviewed. The occurrence report indicated the resident was observed on the floor in the dining room. The resident's activity was unknown at the time of the fall. The resident was alert but disoriented, and the resident was chair bound.</p> <p>Nursing Progress Notes dated 4/28/15 at 1:09 a.m., indicated "Time of fall, location of fall, vital signs at 3:00 p.m., dining room. Description of fall: Resident was sitting at dining room table ready for dinner. When I walked past the dining room door resident was sitting on the floor."</p> <p>The updated 5/2015 care plan indicated the resident was a fall risk with poor safety awareness, impaired mobility, and cognitive deficits. The Nursing approaches were to anticipate and meet the resident's needs. Fall precautions in place. The resident needed a safe environment with even floors, free of spills and/or clutter. A working and reachable call light, the bed in low position at night, handrails on walls, and personal items in reach.</p> <p>Interview with LPN #1 on 5/18/15 at 9:18 a.m., indicated Resident #C does</p>			

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F 329 SS=D Bldg. 00	<p>ambulate and can get out of her wheelchair if she wanted to.</p> <p>Interview with the Director of Nursing on 5/18/15 at 3:15 p.m., indicated the resident should not have been left alone in the dining room with the other residents while the floor was wet from the housekeeper mopping the floor.</p> <p>This Federal Tag relates to Complaint IN00169730</p> <p>3.1-45(a)(2)</p> <p>483.25(l) 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</p>			

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	<p>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 a Gradual Dose Reduction (GDR) was at least attempted one time a year related to mood stabilizers and antidepressant medications for 2 of 5 residents reviewed for unnecessary medication. (Resident #15 &, #31)</p> <p>Findings include:</p> <p>1. On 5/13/15 at 2:48 p.m., Resident #15 was observed sitting in a chair in the Television (TV) room on the Special Care Unit. The resident was awake and was observed with no mood or behavior problems.</p> <p>On 5/14/15 at 9:47 a.m., the resident was observed sitting in a recliner chair in the TV room with her eyes closed. No mood or behavior problems were observed.</p> <p>On 5/15/15 at 8:01 a.m., the resident was observed in the dining room waiting on breakfast with her eyes closed.</p> <p>The record for Resident #15 was reviewed on 5/13/15 at 2:49 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease,</p>	F 329	<p>F329</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Medications have been reviewed by the pharmacist and recommendations have been made for residents 15 and 31.</p> <p>2) How the facility identified other residents:</p> <p>Residents that receive psychotropic medications have been reviewed to identify any other residents that have not had a dosage reduction.</p>	06/12/2015

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	<p>depressive disorder, post traumatic stress syndrome, and dementia with behavioral disturbance.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 4/20/15 indicated the resident was not able to be interviewed. The resident had short and long term memory problems and was moderately impaired for decision thinking. The resident had disorganized thinking, and was short tempered. The resident was easily annoyed 2-6 days during the assessment period. The resident received a an antipsychotic and an antidepressant for 7 days.</p> <p>The updated 4/28/15 care plan indicated the resident was at risk for potential side effects from psychotropic medication. The Nursing approaches were to attempt a GDR.</p> <p>Physician Orders were reviewed. An order with an original date of 8/30/13 and on the current 5/2015 recap indicated Depakote Sprinkles (a mood stabilizer) 125 milligrams (mg) give 2 capsules four times a day.</p> <p>Another Physician Order with an original date of 8/30/13 and on the current 5/2015 recap indicated Effexor (an antidepressant) 75 mg daily.</p>		<p>3) Measures put intoplace/ System changes:</p> <p>Psychotropic/Behavior Management meetings will be held monthly toreview behaviors and residents receiving psychotropic medications to determineif GDR is appropriate or if clinically contraindicated. Residents will be reviewed a minimum ofquarterly to ensure compliance.</p> <p>Social Services Director or designee will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these auditswill be reviewed in Quality Assurance Meeting monthly x3 months, then quarterlyx1 for a total of 6 months.</p> <p>5) Date ofcompliance: June 12, 2015</p>				

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	<p>The resident was also receiving Seroquel (an antipsychotic medication) 100 mg every evening.</p> <p>Social Service Progress Note dated 11/21/14 indicated there had been a decrease in the resident's physical and verbal behaviors during care and refusal of care this quarter.</p> <p>Social Service Progress Notes dated 3/18/15 indicated the resident had no issues with mood, other than resident was easily annoyed and there were no reports of wandering or rejection of care.</p> <p>Nursing Progress Notes for the months of 12/2014, 1/15, 2/15, 3/15, 4/15, and 5/15 indicated there was no documentation the resident had any mood or behavior problems.</p> <p>The psychiatric multi speciality group indicated on 11/12/14 the resident was cheerful, calm and cooperative and appropriate at that time. The resident had no reportable behaviors. Another visit by the psychiatric group dated 12/17/14 indicated the resident was quiet and cooperative. The resident smiles easily and had good eye contact. The resident had no reportable behaviors. Review of the 1/14/15 psychiatric note indicated the</p>			

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	<p>resident had no reportable behaviors and was quiet and calm. Further review of the psychiatric group progress notes indicated there was no attempt recommended to reduce the resident's Depakote and Effexor over the last 22 months.</p> <p>Interview with CNA #1 on 5/18/15 at 9:21 a.m., indicated the resident had no mood or behaviors problems, and was very pleasant and sweet.</p> <p>Interview with LPN #1 on 5/18/15 at 9:25 a.m., indicated the resident was not aggressive and did not have any behaviors. The LPN indicated the resident was not mean and had no mood or behavior problems.</p> <p>Interview with the Director of Nursing on 5/18/15 at 10:15 am indicated there had been no attempts or GDR's for the Depakote and the Effexor since the resident was admitted back in August 2013.</p> <p>2. The record for Resident #31 was reviewed on 5/14/15 at 8:19 a.m. The resident's diagnoses included, but were not limited to, senile dementia, psychosis, and depressive disorder.</p> <p>A Physician's order dated 1/02/14 indicated, Sertraline 50 milligrams (mg),</p>			

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F 371	<p>one tab by mouth daily for depression. A current Physician's order dated 2/21/15 indicated the same order.</p> <p>The current Plan of Care dated 4/9/15 indicated, at risk for side effects related to psychotropic medication use. The interventions included, but were not limited to, Gradual Dose Reduction (GDR) as indicated.</p> <p>There was no evidence of documentation related to Physician or Pharmacy recommendations related to reducing the medication.</p> <p>Interview with the Director of Nursing (DON) on 5/18/15 at 1:51 p.m., indicated there were no GDR attempts made for medication.</p> <p>A current Psychotropic Medication policy dated 1/1/14 provided by the DON on 5/19/15 at 3:18 p.m., indicated "A gradual dose reduction shall be encouraged at least twice yearly. The drug reduction will continue until eliminated or the clinical condition of the resident worsens."</p> <p>3.1-48(b)(2)</p> <p>483.35(i)</p>			

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SS=E Bldg. 00	<p>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, record review and interview, the facility failed to store and serve food under sanitary conditions related to the storage of food, expired food, food being transported uncovered, and dried food spillage in microwave ovens and refrigerators in 1 of 1 Kitchens and in 3 of 5 pantry areas on the units. (The Main kitchen, Rehab, Elm, and Pines Units)</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation Tour on 5/19/15 at 12:45 p.m., with the Dietary Food Manager, the following was observed:</p> <p>a. A cardboard box containing raw chicken legs in a plastic bag, was observed on the top shelf of a wire rack in the walk in refrigerator. The bottom of the box was wet.</p> <p>Interview with the Dietary Food Manager at this time, indicated the box of chicken legs should not have been stored on the</p>	F 371	<p>F371</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>1. Bag of chicken legs was removed from cardboard box, labeled with date, placed on metal tray and placed on bottom shelf. 2. Diced beef cubes were removed and discarded. 3. Dried juice and food spillage was cleaned from refrigerator and microwave in pantry on Rehab</p>	06/12/2015			

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	<p>top shelf of the rack.</p> <p>b. A package of diced beef cubes was dated 5/8/15. There was writing on the package which indicated the beef was to be used for vegetable beef soup.</p> <p>Interview with the Dietary Food Manager at this time, indicated the meat should have been thrown away.</p> <p>2. During observation of the Unit pantries on 5/19/15 at 12:58 p.m., with the Dietary Food Manager, the following was observed:</p> <p>a. There was dried juice spillage in the refrigerator and dried food spillage in the microwave in the Rehab unit pantry.</p> <p>b. There was a plate of half eaten food in the microwave oven on the Elm unit. The Dietary Food Manager at the time, indicated the plate of food was from Monday night's dinner. She indicated this should not have been left in the microwave oven.</p> <p>c. There was a large accumulation of dried food spillage in the microwave oven in the Pines pantry area. There was also an accumulation of dried juice spillage in the refrigerator.</p>		<p>unit and Pines unit.</p> <p>4. Plate of food in microwave on Elm unit was discarded.</p> <p>5. Bowls of pea salad were covered.</p> <p>2) How the facility identified other residents:</p> <p>Food storage areas were checked for any further improperly stored and outdated food, no concerns were noted.</p> <p>Refrigerators and microwaves were checked and cleaned on all units.</p> <p>Food items were checked to ensure they were properly covered prior to transport.</p> <p>3) Measures put into place/ System changes:</p> <p>Dietary staff were re-educated regarding proper food storage, disposal of outdated food, and covering of food prior to transport.</p> <p>Dietary, housekeeping and nursing staff were re-educated regarding cleaning schedules for refrigerators and microwaves on each unit.</p> <p>Dietary Manager or designee will observe food storage areas and unit pantries at least 3 times per week at varied times to ensure proper food storage, disposal and cleaning of refrigerators and microwaves.</p>		

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	<p>Interview with the Dietary Food Manager at this time, indicated all of the above were in need of cleaning.</p> <p>3. On 5/18/15 at 12:10 p.m., there were two dietary staff members observed walking out of the kitchen. Dietary employee #1 was observed pushing a cart and on top of the cart, there were individual bowls of pea salad with a mayonnaise dressing. The bowls were not covered at that time. The dietary employee dropped a napkin and stopped to pick it up and then continued to push the cart down the hallway.</p> <p>At that time, Dietary employee #1 was asked if the bowls should have been covered, she indicated they should have been.</p> <p>Review of the "Dietary Department Guidelines" provided by the Dietary Food Manager on 5/18/15 at 2:00 p.m., indicated the following:</p> <p>- "meats will be stored on the bottom shelves of the refrigerator to prevent drippings from contaminating foods on lower shelves."</p> <p>- "foods will be transported in covered containers that will maintain safe food temperatures."</p>		<p>Dietary manager will observe food transport at least 3 times per week at varied meals to ensure food is properly covered prior to transport.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: June 12, 2015</p>	

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F 431 SS=D Bldg. 00	<p>-"any food item that becomes contaminated by exposure to employee hands, exposure to uncooked foods, falling to the floor, or when held at unsafe temperatures, etc., will be immediately discarded."</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for</p>			

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	<p>storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure the EDK (Emergency Drug Kit) box was locked on 1 of 3 units. (The Pines Unit)</p> <p>Finding includes:</p> <p>On 5/19/15 at 1:25 p.m., the Pines Unit medication room was observed. The EDK box #23 was observed to be unlocked.</p> <p>Interview at the time with LPN #3 indicated the EDK box should have been locked and an order form should have been filled out and faxed to the pharmacy to be replaced.</p> <p>3.1-25(k)(2)</p>	F 431	<p>F431</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: Pharmacy was contacted to replace the EDK box.</p> <p>2) How the facility identified other residents: All EDK boxes were checked to ensure that they were properly tagged.</p>	06/12/2015	

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F 465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for		<p>3) Measures put intoplace/ System changes: Nurses have been educated on the process for EDK use and securing witha plastic lock. Pharmacy willautomatically exchange all EDK boxes three times per week. Pharmacy is supplying a larger quantity ofplastic locks to re-secure the EDK boxes after each use. Random audits will be done 5 times per week at varied times to monitorfor compliance. Discrepancies will beaddressed with re-education/disciplinary action as appropriate. Director of Nursing will be responsible forthe oversight.</p> <p>4) How the corrective actions will be monitored: The results of these auditswill be reviewed in Quality Assurance Meeting monthly x3 months, then quarterlyx1 for a total of 6 months.</p> <p>5) Date of compliance:June 12, 2015</p>		

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	<p>residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a functional and sanitary environment related to broken ceiling tiles, dirty air conditioning filters, marred walls, dirty cove bases and white plaster on walls for 2 of 5 dining rooms. The facility also failed to provide a functional environment related to loose cove bases, and marred doors, marred walls, and marred heat registers on 2 of 3 units throughout the facility. (The Linden and Maple dining rooms and The Pines and Timber Units)</p> <p>Findings include:</p> <p>During the Environmental tour with the Environmental Supervisor on 5/19/15 at 9:45 a.m., the following was observed:</p> <p>The Maple Dining Room:</p> <p>The Maple dining room had a broken ceiling tile, marred walls and cove bases, dried food substances on the cove bases, and white plaster on the wall near the sink.</p> <p>The Linden Dining Room:</p> <p>The Linden dining room had a dirty filter hanging from the air conditioning unit, marred wallpaper, marred walls, dried</p>	F 465	<p>F465 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and state law. 1) Immediate actiontaken for those residents identified: The following list of tasks were placed on a schedule to be completed by June 12, 2015:</p> <p>Maple Dining Room: Replace broken ceiling tile, clean/ paint marred walls andcove bases, sand white plaster and paint wall next to sink. Linden Dining Room: Replaced air conditioning unit filter. Clean/repair/paint marred walls and wallpaper. Cleaned dirt and food substances from cove bases andunderneath the front of the dishwasher.</p> <p>Pines Unit: Room 3-2: Clean/paintmarred walls, base of bathroom door and heat register in bathroom. Room 4-2: Paint/repair marred walls in bathroom and behindbed, replaced missing towel bar and clean/replace stained ceiling</p>	06/12/2015	

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	<p>food substances and spillage on the cove bases, an accumulation of dirt and food substances along the bottom of the cove bases, and an accumulation of dirt underneath the front of the dishwasher.</p> <p>The Pines Unit:</p> <p>a. Room 3-2, marred walls and heat register in the bathroom. The base of the bathroom door was marred. Three residents shared the bathroom.</p> <p>b. Room 4-2, marred walls and a missing towel bar in the bathroom. The wall behind the bed was scratched and marred. There were stained ceiling tiles in the room. Two residents shared the bathroom and the room.</p> <p>c. Room 7-1, scratched and marred bathroom door frame and heat register. There were loose cove bases, and the base of the bathroom door was scratched and marred. Four residents shared the bathroom.</p> <p>d. Room 9-2, wall next to the bed was chipped and marred. The bathroom door frame and heat register was scratched and marred. There were loose cove bases, and the base of the bathroom door was scratched and marred. Four residents shared the bathroom.</p>		<p>times in the room. Room 7-1: Repair and paint doorframe and bathroom door, and repair loose cove bases. Room 9-2: Repair and paint wall next to bed, repair and paint bathroom door frame, base of bathroom door and heat register, and repair loose cove bases. Room 15-1: Repair and paint base of bathroom door, heat register and bathroom door trim. Room 17-2: Repair and paint base of bathroom door, heat register and bathroom door trim. Timber Unit: Room 215-2- Replace bed side floor mat. Room 258-1: Replace bed side floor mat. 2) How the facility identified other residents: Environmental rounds were completed to identify any other repairs and cleaning needed to be completed. 3) Measures put into place/ System changes: Staff will be re-educated regarding process for completing maintenance work order requests. Environmental rounds will be completed weekly on each unit. Any issues will be corrected as identified or placed on a schedule for repairs or cleaning as appropriate. The Maintenance Director and Housekeeping Supervisor will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly</p>	

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	<p>e. Room 15-1, base of the bathroom door and heat register was scratched and marred. The bathroom door trim had chipped paint. Four residents shared the bathroom.</p> <p>f. Room 17-2, base of the bathroom door and heat register was scratched and marred. The bathroom door trim had chipped paint. Four residents shared the bathroom.</p> <p>The Timber Unit</p> <p>a. Room 215-2, the bed side floor mat was cracked and dirty.</p> <p>b. Room 258-1, the bed side floor mat was cracked and dirty.</p> <p>Interview at the time with the Environmental Supervisor at the time indicated all of the above items were in need of cleaning and/or repair.</p> <p>This Federal Tag relates to Complaint IN00169730.</p> <p>3.1-19(f)</p>		<p>x1 for a total of 6 months. 5) Date of compliance: June 12, 2015</p>	