

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2012
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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an extended survey-immediate jeopardy.</p> <p>Survey dates: April 9, 10, and 11, 2012</p> <p>Extended survey dates: April 12, 13, 14, 15, and 17, 2012</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Survey team: Regina Sanders, RN, TC (April 9, 10, 11, 12, 13, 15, and 17, 2012) Sheila Sizemore, RN (April 10,11,12, 13, 14, and 17, 2012) Kelly Sizemore, RN (April 9, 10, 11, 12, 13, 15, and 17, 2012) Marcia Mital, RN (April 9, 10, 11, 12, 13, 14, and 17, 2012)</p> <p>Census bed type: SNF: 23 SNF/NF: 107 Residential: 43 Total: 173</p> <p>Census Payor type:</p>	F0000		

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

TITLE

(X6) DATE

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

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	<p>Medicare: 39 Medicaid: 78 Other: 56 Total: 173</p> <p>Sample: 24 Supplemental sample: 8 Residential Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 4/23/12 Cathy Emswiller RN</p>			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents' physicians were notified of changes in condition related to weight loss and wounds for 2 of 24 residents</p>	F0157	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>a. On 4/10/12 the physician was</p>	05/04/2012			

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	<p>reviewed for physician notification in a total sample of 24. (Residents # 60 and #118)</p> <p>Findings include:</p> <p>1. Resident #60's record was reviewed on 4/10/12 at 9:35 a.m. Resident #60's diagnoses included, but were not limited to, congestive heart failure, COPD (chronic obstructive pulmonary disease), and urinary retention.</p> <p>The resident's weekly wound documentation, dated 4/3/12, indicated the resident had one stage II pressure ulcer on his right buttock.</p> <p>Resident #60 was observed during a skin assessment, with the Eden Unit Manager on 4/10/12 at 2:00 p.m. The Eden Unit Manager removed a dressing, dated 4/9/12, from the resident's right buttock. There were 3 scabbed areas on the resident's right buttock and 3 scabbed areas on the resident's right upper thigh. The Eden Unit Manager indicated she needed to call the physician about the open areas.</p> <p>The resident's Nurses' Notes, dated 04/03/12 through 04/05/12 (last entry in the Nurses' Notes) lacked documentation the resident's physician had been notified</p>		<p>notified related to Resident # 60 additional scabbed areas on resident's right buttock and 3 scabbed areas on the resident's right upper thigh.</p> <p>b. Resident #118 weekly weights and med-pass continue. 1:1 training provided to staff nurses to ensure that any changes in resident weight require immediate physician notification and documentation in the resident's record</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents were skin checked to assure that wound documentation is accurate. Any changes had physician notified and new orders followed.</p> <p>b. A chart audit was completed on all residents. The physician was notified as indicated.</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>a. Nursing staff was re-educated by 5/4/12 that physician is notified immediately of any changes in wounds and proper documentation for accuracy.</p> <p>b. A re-educated on Physician Notification Policy as well as dietary recommendation with significant weight loss will be completed by 5/4/12.</p> <p>4. How the corrective</p>		

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	<p>of the 5 scabbed areas.</p> <p>During an interview on 4/10/12 at 2:25 p.m., the Eden Unit Manager indicated she did not believe the areas developed after the treatment had been completed on the evening shift last night.</p> <p>2. Resident #118's record was reviewed on 4/10/12 at 3:30 p.m. Resident #118's diagnoses included, but were not limited to, dementia, depression, and osteoarthritis.</p> <p>A physician's order, dated 3/10/12, indicated "weekly weights..."</p> <p>The resident's weight record indicated the resident's weight in February 2012 was 103 pounds.</p> <p>A nutritional progress note, dated 2/25/12, indicated "...readmit wt 102# (pounds) ...weight gain desirable...monitor wts and intakes..."</p> <p>The resident's, March 2012, treatment record indicated the resident weight on 3/18/12 was 94 pounds. This was a 10% weight loss from the February 2012 weight of 103 pounds.</p> <p>Review of the nurses' notes lacked documentation to indicate the physician</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.</p> <p>a. The DON/designee will audit one resident per unit 3 days a week for one month, then weekly for 1 month, every other week for one month and then monthly for 3 months, for residents with wounds, for a total of six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p> <p>b. The DON/designee will perform an audit involving every readmission to assess for weight loss and to ensure timely physician notification for six months. Reports of the audits will be reported to the QA meeting monthly for six months. The quality assurance committee will review findings monthly for six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>		

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	<p>had been notified of the resident's weight loss until 4/5/12.</p> <p>During an interview on 4/10/12 at 4:45 p.m., the Eden Unit Manager indicated the physician was not notified of the weight loss until 4/5/12. She indicated it was too long of a time period for the physician to be notified. She indicated they had gotten an order to increase the med pass supplement on 4/5/12.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview, the facility failed to thoroughly</p>	F0225	F Tag 225 - D 1. What corrective action(s)	05/04/2012			

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	<p>investigate an elopement in which the resident exited the building and fell in the parking lot for 1 of 1 resident reviewed for elopement in a total sample of 24. (Resident #175)</p> <p>Findings include:</p> <p>Resident #175's record was reviewed on 4/11/12 at 11:00 a.m. Resident #175's diagnoses included, but were not limited to Alzheimer's disease, diabetes, and hypertension.</p> <p>An Incident/Accident Report, dated 3/23/12 at 7:50 p.m., indicated "I began to hear an alarm. I look into hallway, res chair was at end of hall. I checked outside. Res was found by first floor staff w (with) abrasions to left knee, shin, elbow, pinky and Rt (right) palm...Immediate intervention implemented to prevent re-occurrence: Alarm in place. 1 on 1 with aide. The Investigation Conclusion indicated "...Summary of Comprehensive Investigation: Res was observed lying on the ground in the parking lot. Fall occurred secondary to elopement from building. Res had self ambulated down 2 flights of stairs et (and) out the yard in rain when she was located. Res was assessed multiple abrasions noted. Res assisted back into facility s/ (without)</p>		<p>will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Resident #175 was hospitalized 4/5/12 and returned to the facility 4/12/12 during part of the chart review and survey.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents' elopement assessment which indicate exit seeking behavior will be identified and corrective action according to facility policy with physician and family notification.</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>a. All scheduled staff was re-educated prior to the start of their shift regarding the Missing Resident and Elopement policy</p> <p>b. Re-education of DON/designee related to thorough investigation of Missing Resident and Elopement policy.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. The QCC /designee will audit all elopement investigations related to</p>				

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	<p>further incident no (indicated by O) other injuries noted at this time...Nurse alerted to hallway where exit door alarm was sounding Nurse noted w/c parked by exit door. Nurse went down the stairway to the Eden Unit where staff was alerted to door alarm...Plan of Action to Prevent Reoccurrence: Fall was R/T (related to) elopement no (indicated by O) new interventions will be put into place at this time."</p> <p>The investigation indicated the DoN (Director of Nursing) interviewed RN #1 and LPN #2 on 3/24/12. The form indicated "... (RN #1) left the nurse's station to provide care in a resident's room at the end of Reclaim 2 when she heard the Reclaim 2 back door alarm sound. She immediately exited the room and observed an empty wheelchair at the end of the hall next to the back door. (RN #1) informed another nurse to call Eden Unit (the downstairs unit) to look for (Resident #175). (RN #1) entered the stairwell and walked down the stairs and out the door. It was raining outside. (Resident #175) had been located by the Eden staff. (Resident #175) had fallen in the parking lot. (Resident #175) cooperatively returned with staff to the facility. (Resident #175) informed (RN #1) that she was trying to leave and go home. 15 minute safety checks initiated...</p>		<p>Elopement for thoroughness and accuracy, through use of an investigation checklist. The QCC/designee will report to QA monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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	<p>(LPN #2) stated he went outside looking for (Resident #175). He observed (Resident #175) in the parking lot on the ground...(Resident #175) was assisted up and willingly came into the facility as it was raining outside..."</p> <p>The investigation report lacked interviews from LPN #5 and the CNA's that were on duty.</p> <p>During an interview with the DoN, on 4/12/12 at 12:30 p.m., she indicated she did not interview the CNA's that were on duty.</p> <p>During an interview with the DoN, on 4/13/12 at 12:45 p.m., she indicated she did not interview LPN #5.</p> <p>During an observation and interview on 4/13/12 at 9:20 a.m.,with Maintenance Staff Member #3 present at the nurses' station, the bar on the door on the Reclaim unit was pushed upon and after 5 seconds a faint beep was heard and then the alarm sounded which was not able to be heard at the nurses' station. Maintenance Staff Member #3 indicated the alarm was not able to be heard because it had been set to bypass. He indicated to turn the alarm off the staff had to place the alarm on bypass. He indicated the staff had to push the button</p>			

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	<p>again to reset the alarm. He indicated he was not sure if the staff were aware of the need to push the button again to reset the alarm.</p> <p>During an interview on 4/13/12 at 9:30 a.m., the DoN indicated she had not checked to see if the alarm had been set to bypass or if it had been turned on when the resident had eloped on 3/23/12. The DoN acknowledged she was aware the resident was at risk for elopement and the stairway door had no wanderguard alarm system.</p> <p>During an interview on 4/13/12 at 3 p.m. with LPN #5, she indicated the night Resident #175 exited the building, "I was at break. I eat in the dayroom across from the nurses station, I don't leave the floor. I did not hear the door alarm go off."</p> <p>3.1-28(d)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review and interview, the facility failed to follow their policy related to thoroughly investigating an unusual occurrence in which the resident exited the building and fell in the parking lot for 1 of 1 resident reviewed for elopement in a total sample of 24. (Resident #175)</p> <p>Findings include:</p> <p>Resident #175's record was reviewed on 4/11/12 at 11:00 a.m. Resident #175's diagnoses included, but were not limited to Alzheimer's disease, diabetes, and hypertension.</p> <p>An Incident/Accident Report, dated 3/23/12 at 7:50 p.m., indicated "I began to hear an alarm. I look into hallway, res chair was at end of hall. I checked outside. Res was found by first floor staff w (with) abrasions to left knee, shin, elbow, pinky and Rt (right) palm...Immediate intervention implemented to prevent re-occurrence: Alarm in place. 1 on 1 with aide. The</p>	F0226	<p>F Tag 225 - D</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Resident #175 was hospitalized 4/5/12 and returned to the facility 4/12/12 during part of the chart review and survey.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents' elopement assessment which indicate exit seeking behavior will be identified and corrective action according to facility policy with physician and family notification.</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>a. All scheduled staff was re-educated prior to the start of their shift regarding the Missing Resident and Elopement policy</p>	05/04/2012			

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	<p>Investigation Conclusion indicated "...Summary of Comprehensive Investigation: Res was observed lying on the ground in the parking lot. Fall occurred secondary to elopement from building. Res had self ambulated down 2 flights of stairs et (and) out the yard in rain when she was located. Res was assessed multiple abrasions noted. Res assisted back into facility s/ (without) further incident no (indicated by O) other injuries noted at this time...Nurse alerted to hallway where exit door alarm was sounding Nurse noted w/c parked by exit door. Nurse went down the stairway to the Eden Unit where staff was alerted to door alarm...Plan of Action to Prevent Reoccurrence: Fall was R/T (related to) elopement no (indicated by O) new interventions will be put into place at this time."</p> <p>The investigation indicated the DoN (Director of Nursing) interviewed RN #1 and LPN #2 on 3/24/12. The form indicated "...(RN #1) left the nurse's station to provide care in a resident's room at the end of Reclaim 2 when she heard the Reclaim 2 back door alarm sound. She immediately exited the room and observed an empty wheelchair at the end of the hall next to the back door. (RN #1) informed another nurse to call Eden Unit (the downstairs unit) to look for</p>		<p>b. Re-education of DON/designee related to thorough investigation of Missing Resident and Elopement policy.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. The QCC /designee will audit all elopement investigations related to Elopement for thoroughness and accuracy, through use of an investigation checklist. The QCC/designee will report to QA monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>		

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	<p>(Resident #175). (RN #1) entered the stairwell and walked down the stairs and out the door. It was raining outside. (Resident #175) had been located by the Eden staff. (Resident #175) had fallen in the parking lot. (Resident #175) cooperatively returned with staff to the facility. (Resident #175) informed (RN #1) that she was trying to leave and go home. 15 minute safety checks initiated... (LPN #2) stated he went outside looking for (Resident #175). He observed (Resident #175) in the parking lot on the ground...(Resident #175) was assisted up and willingly came into the facility as it was raining outside..."</p> <p>The investigation report lacked interviews from LPN #5 and the CNA's that were on duty.</p> <p>During an interview with the DoN, on 4/12/12 at 12:30 p.m., she indicated she did not interview the CNA's that were on duty.</p> <p>During an interview with the DoN, on 4/13/12 at 12:45 p.m., she indicated she did not interview LPN #5.</p> <p>During an observation and interview on 4/13/12 at 9:20 a.m., with Maintenance Staff Member #3 present at the nurses' station, the bar on the door on the</p>			

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	<p>Reclaim unit was pushed upon and after 5 seconds a faint beep was heard and then the alarm sounded which was not able to be heard at the nurses' station. Maintenance Staff Member #3 indicated the alarm was not able to be heard because it had been set to bypass. He indicated to turn the alarm off the staff had to place the alarm on bypass. He indicated the staff had to push the button again to reset the alarm. He indicated he was not sure if the staff were aware of the need to push the button again to reset the alarm.</p> <p>During an interview on 4/13/12 at 9:30 a.m., the DoN indicated she had not checked to see if the alarm had been set to bypass or if it had been turned on when the resident had eloped on 3/23/12. The DoN acknowledged she was aware the resident was at risk for elopement and the stairway door had no wanderguard alarm system.</p> <p>During an interview on 4/13/12 at 3 p.m. with LPN #5, she indicated the night Resident #175 exited the building, "I was at break. I eat in the dayroom across from the nurses station, I don't leave the floor. I did not hear the door alarm go off."</p> <p>An undated facility policy, titled, "Reportable Unusual Occurrences",</p>						

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	<p>received as current from the Administrator on 04/17/12 at 11:30 a.m., indicated, "...The following are examples of occurrences...These occurrences will be reported by facility...Abuse...Neglect...Resident Elopement.."</p> <p>A facility policy, dated 11/11/10, titled, "Resident Abuse Investigation", received from the Administrator as current, indicated, "...8. The Abuse Prevention Coordinator...will initiate the investigation of the allegation...The investigation shall consist of the following...a. Interview the person(s) reporting...b. Interview any witnesses to the incident...e. Interview staff members (on all shifts) having contact with he resident during the period of the alleged incident..."</p> <p>A facility policy titled "Missing Resident Elopement," dated 2/3/12, indicated "Policy...Door Alarm Drills will be utilized to ensure exit doors are functioning properly and verify staff competency in door alarm response and elopement prevention...Residents Identified At Risk for Elopement...1...an alarm bracelet will be placed on the resident to audibly alert staff of attempts by the resident to exit...Residents with an elopement incident from the facility either</p>						

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	<p>on or off the grounds shall be considered at higher risk for further attempts at elopement. These residents will have the following precautionary measure implemented to prevent repeat incidents of elopement. 1. Resident will wear an alarm bracelet...The bracelet will be checked weekly to assure that it is functional, and checks will be logged...Door Alarm Drills 1. The facility will conduct a door alarm drill on each shift each quarter. 2. The drills will be coordinated by the administrator and unannounced...7. As a result of the staff response, training will be provided based on findings. 8. The results and follow up of each drill will be maintained by the administrator and reviewed with the safety committee for further recommendations."</p> <p>During an interview with the Administrator, on 4/12/12 at 4:25 p.m., she indicated the door alarm drills were not done, "I would have been the one that done it."</p> <p>3.1-38(a)</p>				

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F0252 SS=B	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>Based on observation and interview, the facility failed to ensure safe, clean, comfortable, and homelike environment related to a broken floor tile, stained ceiling tiles, no cover on a thermostat, and a continuously running water fountain, for 1 of 3 Units. (Eden)</p> <p>Findings include:</p> <p>During the environmental tour, on 4/11/12 from 1:10 p.m. through 3:00 p.m. with the Maintenance Director and Housekeeping Director, the following was observed:</p> <ol style="list-style-type: none"> 1. Room 110 had a broken floor tile. 2. Two ceiling tiles, by the windows by the entrance to the therapy room, had water stains. 3. Room 132 the thermostat did not have a cover on it. During an interview at the time of the observation, the Maintenance Director indicated they had just got new ones in. 	F0252	<p>F Tag 252 - B</p> <ol style="list-style-type: none"> 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. <ol style="list-style-type: none"> a. By 4/12/12 all repairs related to broken floor tile, stained ceiling tile, thermostat cover and leaking drinking fountain had been repaired or removed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken: <ol style="list-style-type: none"> a. On 4/30/12 all maintenance staff and all scheduled housekeeping staff reviewed that the facility must ensure safe, clean, comfortable and homelike environment. b. Reviewed the importance of completion of work order's for any issue relating to items such as broken floor tiles, thermostat covers, leaking water fountains. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: 	05/04/2012

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	<p>4. The drinking fountain was continuously running.</p> <p>3.1-19(f)</p>		<p>a. Review work order procedure discussed through inservice at all staff meeting on 4/18/12.</p> <p>i. Copies of work order handed out during inservice</p> <p>ii. Any staff member who recognizes a problem may complete this form</p> <p>a. Completed forms placed in Maintenance mailbox or under Maintenance door</p> <p>iii. Discussed proper documentation required on work order form</p> <p>iv. Example form now attached to location where blank forms can be found</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: I.e., what quality assurance program will be put into place.</p> <p>a. Maintenance and housekeeping supervisors/designee will perform one environmental audit per week for two months, then one audit every other week for two months, then one every three weeks for two months. All results of audits will be reported to QA monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>	

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure an assessment was completed for a pressure ulcer within the assessment reference date of an admission MDS (Minimum Data Set) assessment for 1 of 24 MDS assessments reviewed for completed assessments. (Resident #130)</p>	F0272	<p>F Tag 272 - D</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. A head to toe assessment was completed on resident #130. The</p>	05/04/2012

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	<p>Findings include:</p> <p>Resident #130's record was reviewed on 4/12/12 at 9:30 a.m. Resident #130's diagnoses included, but were not limited to pressure ulcer, dementia, and anemia.</p> <p>Resident #130's record indicated on 2/17/12, the resident was admitted to the facility with a stage four pressure ulcer (full thickness tissue loss with exposed tendon or muscle).</p> <p>Review of the weekly wound document assessment sheets indicated the resident's stage four pressure ulcer was assessed and measured on 2/17/12 with the next assessment and measurement on 2/28/12. This was 11 days after the admission assessment on 2/17/12.</p> <p>An Admission MDS assessment, dated 2/24/12, indicated the resident assessment reference date for the admission MDS assessment was 2/24/12.</p> <p>The Admission MDS assessment, dated 2/24/12, Section M: Skin Conditions indicated the resident had unhealed pressure ulcers. The "Current Number of Unhealed Pressure Ulcers at Each Stage" was marked with a dash indicating the facility was unable to assess on the admission MDS assessment. The "Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers" were left blank. The</p>		<p>assessment indicated that this resident has one healing stage four pressure ulcer. This assessment has been documented in the wound record and the resident care plan and care record has been updated.</p> <p>b. The 14 day MDS included the measurements.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:</p> <p>a. All residents will be reassessed for skin issues.</p> <p>b. Findings will be documented in the medical record and care plan.</p> <p>c. No other residents were found to be 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> <p>a. MDS team will be re-educated with emphasis on</p> <p>i. Assessment Protocol</p> <p>ii. Accuracy and completeness of assessment</p> <p>iii. Care Plan/Aide care record</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: I.e., what</p>				

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	<p>"Most Severe Tissue Type for Any Pressure Ulcer" was marked with a dash indicating the facility was unable to assess the pressure ulcer.</p> <p>During an interview on 4/12/12 at 9:40 a.m., MDS nurse #2, indicated there was no documented assessment of the pressure ulcer for the reference period of the admission MDS assessment for 2/24/12.</p> <p>During an interview on 4/12/12 at 9:45 a.m., MDS nurse #2 indicated they just gather the information from the record after the assessment reference date.</p> <p>3.1-31(a)</p>		<p>quality assurance program will be put into place.</p> <p>a. All MDS/Care plans for resident with pressure ulcers that are scheduled will be audited by consultant nurse/designee monthly for six months.</p> <p>b. Findings will be reviewed by DON/designee who will report to QA if trends are identified.</p> <p>c. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>		

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F0278 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 record review and interview the facility failed to ensure MDS (Minimum Data Set) assessments were accurate and complete for 1 MDS assessment related to pressure ulcer, in a sample of 24 residents reviewed for the accuracy and completion. (Resident #130)</p> <p>Findings include:</p>	F0278	F Tag 278 – D 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. A head to toe assessment was completed on resident #130. The assessment indicated that this resident has one healing stage four pressure	05/04/2012			

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	<p>Resident #130's record was reviewed on 4/12/12 at 9:30 a.m. Resident #130's diagnoses included, but were not limited to pressure ulcer, dementia, and anemia.</p> <p>Resident #130's record indicated on 2/17/12, the resident was admitted to the facility with a stage four pressure ulcer (full thickness tissue loss with exposed tendon or muscle).</p> <p>Review of the weekly wound document assessment sheets indicated the resident stage four pressure ulcer was assessed and measured on 2/17/12 with the next assessment and measurement on 2/28/12. This was 11 days after the admission assessment on 2/17/12.</p> <p>An Admission MDS assessment, dated 2/24/12, indicated the resident assessment reference date for the admission MDS assessment was 2/24/12.</p> <p>The Admission MDS assessment, dated 2/24/12, Section M: Skin Conditions indicated the resident had unhealed pressure ulcers. The "Current Number of Unhealed Pressure Ulcers at Each Stage" was marked with a dash indicating the facility was unable to assess on the Admission MDS assessment. The "Dimensions of Unhealed Stage 3 or 4</p>		<p>ulcer. This assessment has been documented in the wound record and the resident care plan and care record has been updated.</p> <p>b. The 14 day MDS included the measurements.</p> <p>.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:</p> <p>a. All residents will be reassessed for skin issues.</p> <p>b. Findings will be documented in the medical record and care plan.</p> <p>c. No other residents were found to be 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> <p>a. MDS team will be re-educated with emphasis on</p> <p>i. Assessment Protocol</p> <p>ii. Accuracy and completeness of assessment</p> <p>iii. Care Plan/Aide care record</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: I.e., what quality assurance program will be put into place.</p>	

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	<p>Pressure Ulcers" were left blank. The "Most Severe Tissue Type for Any Pressure Ulcer" was marked with a dash indicating the facility was unable to assess the pressure ulcer.</p> <p>During an interview on 4/12/12 at 9:40 a.m., MDS nurse #2, indicated there was no documented pressure ulcer assessment for the reference period of the admission MDS assessment for 2/24/12. She indicated she needed the measurements and they had not been done in the reference period.</p> <p>During an interview on 4/12/12 at 9:45 a.m., MDS nurse #2 indicated they just gather the information from the record after the assessment reference date.</p> <p>3.1-31(g)</p>		<p>a. All MDS/Care plans for resident with pressure ulcers that are scheduled will be audited by consultant nurse/designee monthly for six months.</p> <p>b. Findings will be reviewed by DON/designee who will report to QA if trends are identified.</p> <p>c. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>	

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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307		
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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop care plans related to cognition, communication, dental, vision, activities, urinary incontinence, and a PICC (peripheral intravenous central catheter) for 6 of 24 residents reviewed for the development of care plans in a total sample 24. (Residents #23, #60, #69, #79, #113 and, #130)</p> <p>Findings include:</p> <p>1. Resident #60's record was reviewed on 4/10/12 at 9:35 a.m. Resident #60's</p>	F0279	<p>F Tag 279 E</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Resident #23's care plan has been updated to reflect the PICC line.</p> <p>b. Resident #60's care plan has been updated to reflect their cognitive loss, communication and dental care.</p> <p>c. Resident #69's care plan has been updated to reflect their status regarding vision.</p> <p>d. Resident #113's care plan was updated to reflect their cognition and</p>	05/04/2012	

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	<p>diagnoses included, but were not limited to, congestive heart failure (CHF), COPD (chronic obstructive pulmonary disease) and urinary retention.</p> <p>An Admission MDS (minimum data set) assessment, dated 11/8/11, indicated the resident had triggered for CAA (care area assessment) for cognitive loss/dementia, communication, and dental care. The CAA Summary, dated 11/14/11, indicated they were proceeding to care planning for cognitive loss, communication, and dental care.</p> <p>The resident's care plans, dated 11/15/11 and updated 2/9/12, lacked documentation of care plans for cognitive loss, communication, and dental care.</p> <p>During an interview on 4/10/12 at 11:30 a.m., the Eden Unit Manager indicated there were not care plans for the resident's cognitive loss, communication, and dental care.</p> <p>2.. Resident #69's record was reviewed on 4/9/12 at 1:15 p.m. Resident #69's diagnoses included, but were not limited to, CHF, dementia, and Parkinson's disease.</p> <p>The resident's Annual MDS, dated 1/20/12, indicated the resident had</p>		<p>communication.</p> <p>e. Resident #79's care plan has been updated to reflect their cognition, communication and activities.</p> <p>f. Resident #130's care plan has been updated to reflect their activity level, and urinary incontinence</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>a. All resident's care plans were reviewed to ensure that any triggered CAA has been addressed appropriately.</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>a. Care Plan team will be re-educated with emphasis on</p> <p>i. Assessment Protocol</p> <p>ii. Accuracy and completeness of triggered CAA</p> <p>4. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. Care plans that are scheduled to be completed during the month will be audited by Resident Assessment Coordinators/designee monthly for total</p>		

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	<p>triggered for CAA for vision and the facility was proceeding to care plan.</p> <p>The resident's care plans, dated 3/5/11 and updated 2/2/12, lacked documentation of a care plan for vision.</p> <p>During an interview on 4/10/12 at 9:40 a.m., the Eden Unit Manager indicated they said they were going to proceed to care plan and there was not a care plan for vision.</p> <p>3. Resident #113's record was reviewed on 4/11/12 at 1:20 p.m. Resident #113's diagnoses included, but were not limited to, seizure disorder, COPD, and dementia.</p> <p>A Significant Change MDS assessment, dated 1/20/12, indicated the resident had triggered on the CAA for cognitive loss, and communication.</p> <p>The resident's care plans, dated 4/19/11 and updated 3/3/12, lacked documentation of care plans for cognitive loss and communication.</p> <p>During an interview on 4/11/12 at 9:50 a.m., the Eden Unit Manager indicated there were not care plans for communication and cognitive loss.</p> <p>4. Resident #130's record was reviewed on 4/12/12 at 9:30 a.m. Resident #130's</p>		<p>of six months.</p> <p>b. Findings will be reviewed by Resident Assessment Coordinator/designee with the DON/designee who will report to QA for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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	<p>diagnoses included, but were not limited to pressure ulcer, dementia, and anemia.</p> <p>An Admission CAA Summary, dated 2/24/12 indicated the facility would proceed to address the triggered areas of urinary incontinence and activities in the resident's care plans.</p> <p>Review of Resident #130's care plans lacked documentation of care plans for the resident's urinary incontinence and activities.</p> <p>During an interview on 4/12/12 at 9:50 a.m., the Eden Unit Manager indicated she could not find an activities or an urinary care plan.</p> <p>5. Resident #79's record was reviewed on 4/10/12 at 4:45 p.m. Resident #79's diagnoses included, but were not limited to, congestive heart failure and edema.</p> <p>Review of a CAA Summary, dated 12/12/2011, indicated the resident would be care planned for the triggered areas of cognition, communication, and activities.</p> <p>Resident #79's care plans lacked documentation of a cognition, communication, and activities.</p> <p>An interview on 4/11/12 at 9:35 a.m.,</p>			

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	<p>MDS nurse #2 indicated she could not find care plans for cognition and communication. She indicated she found an activities care plan in the computer but the staff did not have access to the computer.</p> <p>6. Resident #23's record was reviewed on 04/11/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus.</p> <p>The admission orders, dated 03/23/12 indicated the resident had PICC line (peripherally inserted central catheter) (intravenous catheter).</p> <p>The resident's care plans, dated 03/23/12, 04/04/12, and 04/12/12, lacked documentation to indicate the resident had a care plan for the PICC line.</p> <p>During an interview on 04/11/12 at 2:25 p.m., the Minimum Data Nurse (MDS) #1 indicated there was no care plan for the resident's PICC line.</p> <p>3.1-35(a)</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders related to obtaining a laboratory test, dressing, and administering a medication for 4 of 24 residents reviewed for following physicians orders in a total sample of 24 (Resident #7, #23, #70, and #113)</p> <p>Findings include:</p> <p>1. Resident #113's record was reviewed on 4/11/12 at 1:20 p.m. Resident #113's diagnoses included, but were not limited to, seizure disorder, COPD (chronic obstructive pulmonary disease), and dementia.</p> <p>A physician's order recapitulation, dated 3/12, indicated to obtain a valporic acid (medication for seizure disorder) level monthly.</p> <p>The resident's record lacked documentation of a valporic acid level after January 2012.</p> <p>During an interview on 4/12/12 at 9:15</p>	F0282	<p>F Tag 282 – D 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident #113 – The physician was notified on 4/10/12 that the valporic acid level had not been done in February or March.b. Resident #7 – The physician was notified on 4/10/12 regarding the order for Tylenol which had been dropped off the MAR.c. Resident # 70 – The physician was notified on 4/10/12 that the dressing had not been changed on 4/9/12.d. Resident #23 – The physician was notified on 4/11/12 that Protonix ordered to be administered before breakfast was being administered after breakfast. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken. a. All admissions and intrafacility transfers charts will be audited to ensure lab orders and the results of ordered labs are present and the physician notified. b. Resident's MAR's audited for accuracy and completeness to ensure they match physician orders and that medication is</p>	05/04/2012	

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	<p>a.m., the Eden Unit Manager indicated the resident had returned from the hospital in January with the order for the monthly valporic acid level. She indicated she was unable to find the laboratory requisition to notify the laboratory to draw the valporic acid levels. She indicated the valporic acid levels had not been done in February or March.</p> <p>2. Resident #7's record was reviewed on 04/10/12 at 9:35 a.m. The resident's diagnoses included, but were not limited to, arthritis and dementia.</p> <p>The physician's recapitulation orders, dated 03/12, indicated orders for acetaminophen (pain medication) (originally dated 04/17/09) 325 mg (milligrams), two tablets every morning for degenerative osteoarthritis, acetaminophen 325 mg (originally dated 04/17/09) , one tablet every evening and at bedtime, and acetaminophen 325 mg (originally dated 06/27/11), two tablets every four hours as needed for pain.</p> <p>A physician's order, dated 02/22/12, indicated an order to discontinue acetaminophen 650 mg as needed every four hours and to begin acetaminophen 325 mg every six hours as needed for pain.</p>		<p>administered at appropriate times as it relates to Resident #7 Tylenol order and Resident #23's Protonix order.c. All residents with wounds were reassessed to assure that treatments have been followed according to physician orders. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. a. Nursing staff will be reeducated on lab ordering processb. Nursing staff will be re-educated related to proper transcription of physician orders related to accuracy of medication changes and proper administration times of those ordered medication. c. Re-educate of all nursing staff related to following physician orders as it relates to treatments applied to wounds. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. a. RCC/designee will audit lab book daily and check medical record to ensure lab report is present and physician has been notified for one month, every other week for two months and monthly for three months for a total of six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct</p>		

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	<p>The Medication Administration Record (MAR), dated 04/12, lacked documentation the resident had an order for and received acetaminophen 325 mg, two tablets every morning and one tablet every evening and at bedtime from 04/01/12 through 04/10/12.</p> <p>During an interview on 04/10/12 at 10:30 a.m., the Haven Unit Manager indicated it looked like the pharmacy had dropped the order off the MAR. She indicated the nurse should have found the error when she checked the physician's orders and MARs.</p> <p>3. Resident #70's record was reviewed on 4/10/12 at 11:25 a.m. Resident #70's diagnoses included, but were not limited to, severe peripheral vascular disease, dementia, and diabetes mellitus.</p> <p>A physician's order, dated 3/19/12, indicated "...Cleanse area to L (left) outer foot with normal saline apply bactroban (ointment) Santyl (a debriding ointment)...cover c (with) dry dressing daily and prn (as needed)."</p> <p>Resident #70 was observed on 4/10/12 at 9:28 a.m., 11:30 a.m., and 11:56 a.m., with a dressing to his left foot dated 4/8/12.</p>		<p>and recommend continued monitoring until corrections are effective.b. All Medication Records will be reviewed for accuracy after recapitulation monthly by DON/designee for six months. Audit findings will be presented to the QA committee meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.c. DON/designee will conduct random audits related to dressing changes. The DON/designee will report to QA monthly for six months. The DON/designee will perform a total of two audits per week for two months, then one audit per week for two months and then one audit every other week for two months. All audits will be conducted and reported to QA monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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	<p>During an interview on 4/10/12 at 11:56 a.m., the Eden Unit Manager, indicated the dressing had not been changed since 4/8/12 as ordered by the physician.</p> <p>4. Resident #23's record was reviewed on 04/11/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus.</p> <p>The physician's recapitulation orders, dated 04/12, indicated an order, originally dated 03/23/12, for Protonix (stomach medication) 20 mg every morning before breakfast.</p> <p>The resident's MAR, dated 04/12, indicated the resident's Protonix was being given at 9 a.m.</p> <p>During an interview on 04/11/12 at 1:50 p.m., day shift LPN #7 indicated the Protonix was not given before breakfast. She indicated the resident's breakfast arrives around 7:30 a.m. She indicated the Protonix was given at 7 a.m. in March and the nurse who checked the MARs for April did not catch it.</p> <p>3.1-35(g)(2)</p>						

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to provide the necessary care and services related to wound assessment and care, assessing and treating pain, and following dietary recommendations for a stasis ulcer for 2 of 5 residents with wounds and 1 of 24 residents reviewed for risk of pain in a total sample of 24. (Residents #42, #70, and #60)</p> <p>Findings include:</p> <p>1. Resident #60's record was reviewed on 4/10/12 at 9:35 a.m. Resident #60's diagnoses included, but were not limited to, congestive heart failure, COPD (chronic obstructive pulmonary disease), and urinary retention.</p> <p>The resident's weekly wound documentation, dated 4/3/12, indicated the resident had one stage II pressure ulcer on his right buttock;</p> <p>Resident #60 was observed during a skin</p>	F0309	F Tag 309 – D 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. One 4/10/12 the physician was notified related to Resident #60's additional scabbed areas on resident's right buttock and 3 scabbed areas on resident's right upper thigh which wound care specialist stated did not show pressure characteristics but rather moisture related excoriation/fungal infection. b. Resident #70's physician was notified of dietary recommendation with albumin level drawn which was found to be in normal range. c. Regarding resident #42, nursing staff were re-educated to ensure that the proper procedure for documentation of a PRN pain medication is followed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. All residents were skin checked to assure that wound documentation	05/04/2012

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	<p>assessment, with the Eden Unit Manager on 4/10/12 at 2:00 p.m. The Eden Unit Manager removed a dressing, dated 4/9/12, from the resident's right buttock. There were 3 scabbed areas on the resident's right buttock and 3 scabbed areas on the resident's right upper thigh. The Eden Unit Manager indicated she needed to call the physician about the open areas and obtain a treatment.</p> <p>During an interview on 4/10/12 at 2:25 p.m., the Eden Unit Manager indicated she did not believe the areas developed after the treatment had been completed on the evening shift last night.</p> <p>A Wound Care Specialist Initial Evaluation, dated 04/11/12, indicated, "...Large area that does not show pressure characteristics but rather moisture related excoriation/fungal infection..."</p> <p>2. Resident #70's record was reviewed on 4/10/12 at 11:25 a.m. Resident #70's diagnoses included, but were not limited to, severe peripheral vascular disease, dementia, and diabetes mellitus.</p> <p>A nutritional progress note, dated 3/22/12, indicated "RD Note: Resident returned on 3/14/12 from hospital stay for Dx (diagnosis) of infected foot L. Per wound nurse L heel ulcer closed, has a</p>		<p>is accurate,. Any changes had physician notified and new orders followed. b. Dietary recommendations from March 22 nd forward will be reviewed to ensure that all recommendations have been followed up. c. All resident's with PRN medication orders for pain have the potential for this practice to occur. A record review was conducted of all resident's receiving PRN pain medication. If deficiencies were noted the individual nurse received 1:1 re-instruction regarding the Pain Management Policy. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. a. Nursing staff was re-education by 5/4/12 that physician is notified immediately of any changes in wounds and proper documentation for accuracy. b. Re-educated RCC/designee regarding dietary recommendations and follow through. c. Nursing staff will be re-educated regarded Pain Management Policy regarding PRN medication. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. a. The DON/designee will audit one resident per unit 3 days a week for one month, then weekly for 1 month, every other week for one month and then monthly for 3</p>		

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	<p>stasis ulcer L outer foot....Will request obtain Pre Albumin to assess visceral protein status..."</p> <p>During an interview on 4/10/12 at 12 p.m., the Eden Unit Manager indicated the RD recommendation had not been followed up on.</p> <p>3. Resident #42's record was reviewed on 04/10/12 at 2:45 p.m. The resident's diagnoses included, but were not limited</p>		<p>months, for residents with wounds, totaling six months. . Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.b. The DON/designee will perform an audit involving dietary recommendations to ensure that they are followed through appropriately weekly, on a ongoing basis and report the findings to the Quality Assurance meeting monthly. If deficiencies are noted the quality Assurance Committee will develop plans of action to correct the identified deficiencies.c. The DON/designee will audit pain flow record for PRN medication for accuracy daily for one month, then three times per week for one month, twice a week for one month and then weekly for three months for a total of six months . Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>		

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	<p>to, diabetes mellitus and hypertension.</p> <p>The Admission/5-day Minimum Data Assessment, dated 02/29/12, indicated the resident's cognitive summary score was 10 (impaired cognition), could understand communication and her communications could be understood, and had pain frequently at a score of 10 (worst pain).</p> <p>The care plan, dated 03/05/12, indicated there was a potential for alteration in comfort. The approaches included, "1. give pain meds (medications) as ordered assess and document...2. check possible causes of pain/discomfort assess and document pain characteristics...4. assess pain using 1-10 scale..."</p> <p>The physician's recapitulation orders, dated 04/12, indicated an order, dated 03/12/12, for tramadol (pain medication) 50 mg (milligrams) every six hours as needed for pain and an order dated 03/14/12, for Acetaminophen (pain/temperature medications) 325 mg, two tablets as needed for pain or temperature every four hours.</p> <p>The resident's Medication Administration Record (MAR), dated 03/12, indicated the resident received the tramadol on March 19, 20, 21 (twice), 22, 23, 26, 27, and 30, 2012 for complaints of pain. There was a</p>						

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	<p>lack of documentation to indicate the resident's pain had been assessed prior to administering the acetaminophen.</p> <p>The MAR, dated 03/12, indicated the resident received the acetaminophen on March 12, 2012 for complaints of pain and March 26, 2012, no reason documented. There was a lack of documentation to indicate the resident's pain had been assessed prior to administering the acetaminophen.</p> <p>The MAR, dated 04/12, indicated the resident received the tramadol on April 6, 7, 8, 9, 2012 and the acetaminophen on April 3, 2012. There was a lack of documentation to indicate the resident's pain had been assessed prior to administering the pain medications.</p> <p>During an interview on 04/10/12 at 2:30 p.m., The Reclaim Unit Manager indicated the nurses are suppose to assess the pain prior to giving the pain medication. She indicated the resident could verbalize the rating of her pain. She indicated there were no pain assessments completed on the dates given in March and April of 2012.</p> <p>A facility policy, dated 10/10/10, titled, "Pain Management", received from the Assistant Director of Nursing as current,</p>						

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	indicated, "...Pain management flow documentation (form to assess the pain) is completed: Each time a PRN (as needed) medication is being administered..." 3.1-37(a)				

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F0314 SS=E	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to ensure Registered Dietician (RD) recommendation to promote healing of pressure ulcers were followed up on for 5 of 5 residents reviewed for pressure ulcers in a total sample of 24. (Residents #60, #62, #69, #79 and #113)</p> <p>Findings include:</p> <p>1. Resident #60's record was reviewed on 4/10/12 at 9:35 a.m. Resident #60's diagnoses included, but are not limited to, congestive heart failure (CHF), COPD (chronic obstructive pulmonary disease), and urinary retention.</p> <p>A nutritional progress note, dated 3/22/12, indicated " RD note: Per wound Nurse, resident has a stage II (partial thickness loss of dermis presenting as a shallow open ulcer) on R (right)</p>	F0314	<p>F Tag 314</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Resident #60, #69, #113, #62 and #79 on 4/10/12 physician was notified of dietary recommendations with appropriate follow through.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Dietary recommendations from March 22 nd forward will be reviewed to ensure that all recommendations have been followed up.</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>a. Re-educated RCC/designee</p>	05/04/2012			

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	<p>buttock...Recommend 1. Vit (vitamin) C 500 mg (milligrams) BID (twice a day) 2. ZnSO4 (Zinc) 220 mg daily x (times) 30 days. 3. Obtain BMP (basic metabolic panel) and Pre Albumin levels..."</p> <p>The resident's record lacked documentation to indicated there was any follow up related to the resident's RD recommendations, dated 3/22/12.</p> <p>During an interview on 4/10/12 at 11:30 a.m., the Eden Unit Manager indicated the RD recommendation had not been followed up on.</p> <p>2. Resident #69's record was reviewed on 4/9/12 at 1:15 p.m. Resident #69's diagnoses included, but were not limited to, CHF, dementia, and Parkinson's disease.</p> <p>A nutritional progress note, dated 3/22/12, indicated "RD Note: Resident c (with) new pressure ulcer stage II L (left) buttock....Will request current Pre Albumin to assess visceral protein status...Further recommendations maybe warranted if Pre Albumin level low..."</p> <p>The resident's record lacked documentation to indicated there was any follow up related to the resident's RD recommendations, dated 3/22/12.</p>		<p>regarding dietary recommendations and follow through.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. The DON/designee will perform an audit involving dietary recommendations to ensure that they are followed through appropriately weekly. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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	<p>During an interview on 4/10/12 at 9:50 a.m., the Eden Unit Manager indicated the RD recommendation had not been followed up on.</p> <p>3. Resident #113's record was reviewed on 4/11/12 at 1:20 p.m. Resident #113's diagnoses included, but were not limited to, seizure disorder, COPD, and dementia.</p> <p>A nutritional progress note, dated 3/22/12, indicated "RD Note: Per current wound report, area on coccyx has reopened stage II 2.2 x (by) 1.5 x < (less than) 0.1 cm (centimeters), stage III (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed) area on l (left) foot...new stage II area bunion...Will request current Pre Albumin level to assess visceral protein status...Will recommend add Prostat (protein supplement)..."</p> <p>The resident's record lacked documentation to indicated there was any follow up related to the resident's RD recommendations, dated 3/22/12.</p> <p>During an interview on 4/11/12 at 2:15 p.m., the Eden Unit Manager indicated the RD recommendation had not been followed up on.</p>						

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	<p>4. Resident #62's record was reviewed on 4/12/12 at 9:06 a.m. Resident #62's diagnoses included, but were not limited to, dementia, depression, COPD, and hypertension.</p> <p>A nutritional progress note, dated 3/22/12, indicated "RD Note: Per wound nurse, resident has stage II pressure ulcers on B (bilateral) buttock...Recommend add ZnSO4 220 mg daily x 30 days, Prostat...daily. Request Pre Albumin level to assess visceral pro (protein) status..."</p> <p>The resident's record lacked documentation to indicated there was any follow up related to the resident's RD recommendations, dated 3/22/12.</p> <p>During an interview on 4/12/12 at 9:52 a.m., the Eden Unit Manager indicated the RD recommendation had not been followed up on.</p> <p>5. Resident #79's record was reviewed on 4/10/12 at 4:45 p.m. Resident #79's diagnoses included, but were not limited to, congestive heart failure and edema.</p> <p>A nutritional progress note, dated 3/22/12, indicated "...L (left) inner buttock stage II reopened. Has stage II pressure ulcer on R (right) buttock...Will</p>						

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	<p>recommend current Pre Albumin (protein level) and BMP (basic metabolic profile) levels be obtained....."</p> <p>Review of the resident's record lacked documentation of the dietary recommendations being followed.</p> <p>During an interview on 4/11/12 at 9:10 a.m., the Eden Unit Manager indicated she did not receive the dietary recommendation for 3/22/12. She indicated she had ordered the two labs.</p> <p>An undated facility policy, titled "Dietary Recommendations," and received by the DoN on 4/11/12 at 2:35 p.m., indicated "Purpose: To ensure proper and timely follow up on Dietary recommendations...2. The Dietitian will forward the recommendation to the appropriate Nurse Unit Manager. 3. The appropriate Nurse Unit Manager will follow up on the recommendation within seven (7) days of receipt...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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F0322 SS=D	<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 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 a resident with a gastrostomy tube (g-tube) (feeding tube) received appropriate treatment related to checking the g-tube for placement for 1 of 1 residents reviewed with gastric tubes in a total sample of 24. (Resident #113)</p> <p>Findings include:</p> <p>During an observation on 04/10/12 at 5:10 p.m., LPN #15 prepared Resident #113's medications and entered the resident's room to administer the medications.</p> <p>LPN #15 clamped the g-tube, disconnected the tube feeding, put a syringe into the g-tube tubing and aspirated a small amount of liquid feeding into the syringe. LPN #15 did not inject air into the g-tube with the syringe so he could auscultate the g-tube placement</p>	F0322	<p>F 322 – D</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. 4/10/12 Resident #113 was assessed to determine that she had no ill effects as a result of lack of checking g-tube for placement prior to administering medication.</p> <p>b. On 4/10/12, LPN #15 received re-education related to checking the g-tube for placement prior to administration of medication.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents with a g-tube have the potential for the deficient practice.</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>	05/04/2012			

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	<p>with a stethoscope. LPN #15 then added water to each cup with crushed medications and stirred the medications and bolused the medications and flushes through the g-tube by gravity. LPN #15 did not check the resident's g-tube for placement.</p> <p>During an interview at the time of the observation, LPN #15 indicated it was not the facility's policy to check for placement of the g-tube. He indicated it was the policy to only check for residual.</p> <p>A facility policy, dated 04/03/12, titled, "Enteral Administration of Medications", received from the Assistant Director of Nursing as current, indicated, "...7. With a 60 cc (cubic centimeter) syringe, verify tube placement via auscultation with a stethoscope and check for residual gastric contents by aspirating on the syringe..."</p> <p>3.1-44(a)(2)</p>		<p>a. All nursing staff will be re-educated related to checking the g-tube for placement prior to administration of medication.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. Two nurses/QMA per week to return demonstrate checking for g-tube placement check for six months. Reports will be reported to QA meeting monthly for six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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F0323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a known history of exit seeking behavior was supervised to prevent elopement from the facility resulting in the resident going down two flights of stairs and out into the parking lot and falling sustaining multiple abrasions with the potential for serious harm (Resident #175) and failed to assess and apply interventions in a timely manner for a resident at risk for elopement (Resident #31) for 2 of 3 residents residing on the Reclaim unit who were at risk for elopement.</p> <p>This immediate jeopardy began on 3/23/12 when the resident eloped from the facility. The Administrator and Director of Nurses were notified of the immediate jeopardy at 4:30 p.m. on 4/12/12. The immediate jeopardy was removed on 4/15/12, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p>	F0323	<p>F 323 – J Abatement of Immediate Jeopardy – Failure to Supervise Resident 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident # 175 returned to the facility 4/12/12. A new elopement assessment was completed upon arrival, alarm bracelet applied, and care plan updated with approaches and interventions that relate to her history of exit seeking behavior. b. Due to the residents exit seeking behavior, facility providing one –to-one supervision upon her return. c. Resident's family notified and approved facility to place resident on facility's lower level unit d. Facility will continue one-to-one supervision during residents waking hours until facility determines a change in resident's behavior resulting in non-exit-seeking activity. e. Facility's interdisciplinary team and resident physician will then readjust the one-on-one appropriately. f. Resident #31 had a new elopement assessment completed and alarm</p>	05/04/2012

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			bracelet applied with care plan updates including approaches and interventions related to her new exit seeking behavior. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. All residents have had their elopement assessments updated, care planned reviewed and updated as needed. b. If clinically indicated, an alarm bracelet was placed on the resident to audibly alert staff of any attempts by the resident to exit. If behavior indicates, additional one-to-one staffing will be provided to ensure resident safety. c. All elopement binders are current and up-to-date and located at front desk and all nursing units. d. All residents who attempt to leave the facility more than one time in a twenty-four(24) hour period, will be placed on every 15 minute safety check for forty-eight(48) hours. If exacerbation of the behavior continues, 1:1 supervision will be initiated. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. All scheduled staff re-educated on Missing Resident and elopement policy. b. Continued education for all oncoming staff on Missing Resident and elopement policy prior to beginning their scheduled	

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			<p>shift. c. Staff will be educated upon hire and quarterly on Missing Resident and elopement policy. In addition, quarterly drills will be conducted on all three shifts per facility policy. d. Nurses will be re-educated on the policy for reporting Missing resident and elopement to the Administrator/designee immediately regardless of time of day. e. Exit door alarm systems that are capable of adjustment, have been turned to the highest volume. Other exit doors have had additional devices added to increase volume. f. Additional alarm attached to Reclaim II fire exit that will alarm when panic bar is pressed. Wanderguard system has been expanded to include Reclaim II, Eden unit C and D hall. g. Continued monitoring of Fire exit door until 4/16/12 at 15 minute intervals when update system had been installed and was fully functional. h. All exit doors checked weekly by maintenance to assure proper function. i. Social service will discuss at the morning clinical meeting all residents exhibiting exit seeking behaviors, approaches and interventions, to determine their effectiveness. Changes will be made if appropriate. Any resident exhibiting exit seeking behavior will be tracked and resident specific approaches/interventions will be added to the care plan as determined by the</p>	

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			interdisciplinary team. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. a. Random interviews with pre-determined questions will be conducted to assure that the education on Missing resident and elopement is successful. Nine(9) staff members from nursing department daily for one month(3 per shift) and two (2) staff members from non-nursing department one(1) per shift, then nine (9) staff members from nursing department and two (2) from non-nursing departments three time a week for one month and the same number of staff two times per week for one month then same number of staff once per week for three months. These random interviews will be submitted to the Quality Assurance Committee and continue to be conducted quarterly on three staff members per shift per quarter to assure continued compliance with staff knowledge and competency of the protocol until the compliance is maintained as determined by the Quarterly Assurance Committee review. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct		

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	<p>Findings include:</p> <p>Resident #175's record was reviewed on 4/11/12 at 11:00 a.m. Resident #175's diagnoses included, but were not limited to Alzheimer's disease, diabetes, and hypertension.</p> <p>A nurse's note, dated 3/14/12 at 1:30 p.m., indicated "...Repeatedly requested to leave. CNA's walked with her and attempted to redirect. Called daughter (name) res (resident) told daughter that she will slit her throat if she doesn't get out of here. Res then preceded to curse at daughter..."</p> <p>A nurse's note, dated 3/14/12 at 6 p.m., "(name) ambulance here to pick up resident and send to (name of hospital) ER (Emergency Room)..."</p> <p>A hospital psychiatric evaluation, dated 3/14/12, indicated "...History of present illness:...female who has been living with her adopted daughter for the past 7 years. The adopted daughter was able to care for her initially but lately she has been wandering away from the house, started falling and her dementia got worse...The patient has been agitated, upset, being at</p>		and recommend continued monitoring until corrections are effective.	

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	<p>the nursing home and she wants to go home...So yesterday when the daughter called her, apparently she was threatening to harm herself if she let her stay at the nursing home..."</p> <p>Resident #175 was readmitted to the facility on 3/16/12.</p> <p>An elopement assessment, dated 3/16/12, indicated the resident was physically able to leave the building on their own, had a diagnosis of Alzheimer's or dementia and was mobile, had a history of attempting to exit the building, displayed persistent anger at family, staff, current placement, had a history of wandering, had impaired decision-making abilities, impaired safety awareness, and a diagnosis of dementia or related disorder. The assessment indicated "resident's are at High Risk for Elopement when "Yes" is answered to both questions in section A (physically able to leave the building on their own and a diagnosis of Alzheimer's or dementia and is mobile, both answered yes), or have a score of 5 or greater." The resident's score was 9. The comments section indicated "Resident expressing anger toward placement. Resident states that she want (sic) to go home. Exit seeking."</p> <p>An admission MDS (minimum data set)</p>				

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	<p>assessment, dated 3/27/12, indicated the resident had severe cognitive impairment. The resident had wandered daily which had placed the resident at significant risk of getting to a potentially place (stairs/outside of the facility). The resident required extensive assistance of one staff member for transfers and limited assistance of one staff member for ambulation.</p> <p>A care plan, dated 3/9/12, indicated the "Resident exhibits exit seeking behav (behaviors) and no safety awareness, wanderguard...Interventions...maintain functioning of device...monitor whereabouts...initiate psych services, provide 1:1 services prn (as needed)."</p> <p>Nurses' notes on the following dates and times indicated:</p> <p>3/16/12 at 6:15 p.m., "...wanderguard is on resident..."</p> <p>3/17/12 at 4:47 p.m., "Res (resident) continues to be a 1:1 at all times..."</p> <p>3/19/12 at 2:30 p.m., "...safety (check mark) (checks) cont (continue)..."</p> <p>3/20/12 at 1:40 p.m., "res (resident) non-compliant c/ (with) safety ambulating and transferring self..."</p> <p>3/20/12 at 11 p.m., "...Res tries to leave facility, and wanders in other res rooms...requires 1:1 care while awake to</p>			

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	<p>promote safety...encouraged to remain in w/c (wheelchair), or have a staff member walk with Res at all times." 3/21/12 at 9 p.m., "...Resident has been trying to leave facility and becomes combative to staff. Requires 1:1 care while awake for safety...staff member needs to be with resident." 3/23/12 at 7:15 p.m., "...Wanderguard is in place. Res continuously (sic) tries to wander off unit. Res resists and becomes combative when staff tries to retrieve her." 3/23/12 at 7:50 p.m., "Alarm began to sound. I looked down hall to see Res wc (wheelchair) near exit door. I went downstairs and looked outside. Res had been found by 1st floor staff. Res stated she was leaving and was going home. Staff was able to calm Res and she returned to unit cooperatively..."</p> <p>Social Services notes on the following dates and times indicated:</p> <p>3/20/12 at 11 a.m., "Writer met c/ (with) Resident in hallway sitting in w/c (wheelchair) asking staff to take her outside and requesting to go home..." 3/22/12 at 10:05 a.m., "...Resident discussed of her cont. (continue) to wish leaving (sic) and going home. On elopement risk..."</p>			

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	<p>3/26/12 at 9:30 a.m., "Writer informed by Administrator, of Res. exit out of bldg (building). over wk-end (weekend), all measures were in place at @ time of exit...Met c/ (with) Resident RE: above incident, could not recall, was asking writer how to get out of facility..."</p> <p>An Incident/Accident Report, dated 3/23/12 at 7:50 p.m., indicated "I began to hear an alarm. I look into hallway, res chair was at end of hall. I checked outside. Res was found by first floor staff w (with) abrasions to left knee, shin, elbow, pinky and Rt (right) palm...Immediate intervention implemented to prevent re-occurrence: Alarm in place. 1 on 1 with aide. The Investigation Conclusion indicated "...Summary of Comprehensive Investigation: Res was observed lying on the ground in the parking lot. Fall occurred secondary to elopement from building. Res had self ambulated down 2 flights of stairs et (and) out the yard in rain when she was located. Res was assessed multiple abrasions noted. Res assisted back into facility s/ (without) further incident no (indicated by O) other injuries noted at this time...Nurse alerted to hallway where exit door alarm was sounding Nurse noted w/c parked by exit door. Nurse went down the stairway to the Eden Unit where staff was alerted to</p>						

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	<p>door alarm...Plan of Action to Prevent Reoccurrence: Fall was R/T (related to) elopement no (indicated by O) new interventions will be put into place at this time."</p> <p>The investigation indicated the DoN (Director of Nursing) interviewed RN #1 and LPN #2 on 3/24/12. The form indicated "...(RN #1) left the nurse's station to provide care in a resident's room at the end of Reclaim 2 when she heard the Reclaim 2 back door alarm sound. She immediately exited the room and observed an empty wheelchair at the end of the hall next to the back door. (RN #1) informed another nurse to call Eden Unit (the downstairs unit) to look for (Resident #175). (RN #1) entered the stairwell and walked down the stairs and out the door. It was raining outside. (Resident #175) had been located by the Eden staff. (Resident #175) had fallen in the parking lot. (Resident #175) cooperatively returned with staff to the facility. (Resident #175) informed (RN #1) that she was trying to leave and go home. 15 minute safety checks initiated... (LPN #2) stated he went outside looking for (Resident #175). He observed (Resident #175) in the parking lot on the ground...(Resident #175) was assisted up and willingly came into the facility as it was raining outside..."</p>			

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	<p>During an interview with the DoN, on 4/12/12 at 12:20 p.m., she indicated "The door (exit door at the end of Reclaim Unit) will sound when it is open. It is locked for fire safety and will unlock after 15 seconds. The nurse was 2 or 3 rooms down from where the resident went out the door. She heard the alarm, seen the empty wheelchair and told the other nurse to call downstairs. She indicated "When (Resident #175) wants to, she can move fast."</p> <p>During an observation with the DoN, on 4/12/12 at 12:35 p.m., of the door to the stairwell where Resident #175 went down 2 flights of stairs, the DoN pushed on the door which then began a faint beep. After 15 seconds the door opened and a louder alarm sounded. The door opened to 2 flights of stairs which led to a foyer with 2 doors, one leading outside and one going into the Eden Unit. The door leading outside did not have any type of alarm on it.</p> <p>Outside the door there was a sidewalk that led to a parking lot. The DoN identified the area where the resident had fallen in the parking lot. This took approximately 1 1/2 minutes. During an interview at the time of the observation, the DoN indicated she did not inservice the staff because they followed the elopement</p>			

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	<p>policy. She indicated the resident was put on every 15 minute safety checks. She indicated the day the resident eloped, the resident was not on one to one with staff. She indicated the resident was not put in the Haven Unit (locked Alzheimer's unit) because the resident was "claustrophobic."</p> <p>During an interview with the DoN, on 4/12/12 at 2:30 p.m., she indicated there were times the resident was on one to one. She indicated the resident's physician wanted the resident to be placed on the locked Alzheimer's Unit (Haven Unit). She indicated the Haven Unit was not discussed with the family until after the elopement.</p> <p>During an interview with the Administrator, on 4/12/12 at 4:25 p.m., she indicated the door alarm drills were not done, "I would have been the one that done it."</p> <p>During an observation and interview on 4/13/12 at 9:20 a.m., with Maintenance Staff Member #3 present at the nurses' station, the bar on the door on the reclaim unit was pushed upon and after 5 seconds a faint beep was heard and then the alarm sounded which was not able to be heard at the nurses' station. Maintenance Staff Member #3 indicated the alarm was not</p>						

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	<p>able to be heard because it had been set to bypass. He indicated to turn the alarm off the staff had to place the alarm on bypass. He indicated the staff had to push the button again to reset the alarm. He indicated he was not sure if the staff were aware of the need to push the button again to reset the alarm.</p> <p>During an interview on 4/13/12 at 3 p.m. with LPN #5, she indicated the night Resident #175 exited the building, "I was at break. I eat in the dayroom across from the nurses station, I don't leave the floor. I did not hear the door alarm go off."</p> <p>During an interview on 4/13/12 at 9:30 a.m., the DoN indicated she had not checked to see if the alarm had been set to bypass or if it had been turned on when the resident had eloped on 3/23/12. The DoN acknowledged she was aware the resident was at risk for elopement and the stairway door had no wanderguard alarm system.</p> <p>During an interview on 4/13/12 at 9:45 a.m., the Corporate Regional Vice President acknowledged a resident with exit seeking behaviors should have been placed on one on one with staff.</p> <p>During an observation and interview on 4/13/12 at 9:50 a.m., Maintenance Staff</p>						

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	<p>Member #3 indicated the west emergency exit door (the stairwell door the resident had eloped through) on the reclaim unit did not show up on the door panel indicator, located in the reclaim nurses' station, to let the staff know the door had been opened.</p> <p>A facility policy titled "Missing Resident Elopement," dated 2/3/12, indicated "Policy...Door Alarm Drills will be utilized to ensure exit doors are functioning properly and verify staff competency in door alarm response and elopement prevention...Residents Identified At Risk for Elopement...1...an alarm bracelet will be placed on the resident to audibly alert staff of attempts by the resident to exit...Residents with an elopement incident from the facility either on or off the grounds shall be considered at higher risk for further attempts at elopement. These residents will have the following precautionary measure implemented to prevent repeat incidents of elopement. 1. Resident will wear an alarm bracelet...The bracelet will be checked weekly to assure that it is functional, and checks will be logged...Door Alarm Drills 1. The facility will conduct a door alarm drill on each shift each quarter. 2. The drills will be coordinated by the administrator and unannounced..."</p>			

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	<p>The immediate jeopardy that began on 3/23/12 was removed on 4/15/12 when the facility implemented every 15 minute safety checks on exit doors until the wanderguard alarm is installed, revised elopement policy, the staff were educated on the revised elopement policy prior to working. Staff were interviewed on the revised elopement policy and were able to verbalize what they are to do if a resident was a wonder risk, exit seeking, and/or if the resident elopes from the building. The facility had inserviced 94 out of 254 employees. Door checks were being completed every 15 minutes and monitored by the designee and elopement drills had been conducted.</p> <p>2. Resident #31's record was reviewed on 4/13/12 at 9:10 a.m. Resident #31's diagnoses included, but were not limited to, dementia and deep vein thrombosis.</p> <p>An Admission MDS assessment, dated 2/09/12, indicated the resident was alert and oriented. The MDS assessment indicated the resident was extensive assistance of one staff member for transfers. The MDS assessment indicate the resident used a walker and wheelchair for mobility.</p> <p>An elopement assessment, completed on 2/2/12 indicated the resident was not at</p>						

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	<p>risk for elopement from the facility.</p> <p>A nurses' note, dated 2/17/12 at 3:40 a.m., a late entry for 2/16/12 at 3:50 p.m., indicated the front desk secretary came to the nurse and indicated the resident was very confused and wanted to call her sister. The nurses' note, indicated the resident wanted her sister to come and get her and that she had walked to the facility and did not know where she was at. The note indicated the nurse went to the front desk, located on the same floor as the Reclaim unit, and redirected the resident and wheeled the resident back to her room.</p> <p>There was a lack of documentation in the nurses' notes of any further behaviors or of the resident being off of the Reclaim Unit.</p> <p>There was a lack of documentation of another elopement assessment being completed on the resident.</p> <p>A Social Service note, dated 4/5/12, indicated "Writer heard concerns the res. (resident) may try to exit seek. Not noted in Nsg (Nursing) notes. Spoke to rcc (resident care coordinator) - who will speak c/ (with) floor nurses. Elopement assessment updated score does not warrant wanderguard."</p>			

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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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	<p>An elopement assessment, completed on 4/5/12, indicated a score of four a score of five indicates high risk. The comment section of the elopement assessment indicated "Res. recently attempted to exit. Wanderguard applied."</p> <p>During an interview on 4/13/12 at 9:52 a.m., the Social Service Designee indicated she was not aware of the resident being up at the front desk on 2/16/12. She indicated that nursing staff had come to her about the concerns of the resident wandering. She indicated the nursing staff had requested she complete an elopement assessment. She indicated the resident had a wanderguard placed on her on 04/05/12.</p> <p>During an interview on 4/13/12 at 9:55 a.m., the Social Service Supervisor indicated she was unaware of the resident going to the front desk on 02/16/12.</p> <p>During an interview on 4/13/12 at 10:05 a.m., the DoN indicated she was aware the resident made it to the front desk on 2/16/12. The DoN indicated she didn't know the resident was wanting to go home. She indicated she was not aware of the nursing staff concerns to social services about the resident.. The DoN indicated residents were allowed to go to</p>			

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	the Bistro for coffee but "to go to the front lobby to the front door is elopement." 3.1-45(a)(2)			

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F0325 SS=D	<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.</p> <p>Based on record review and interview, the facility failed to ensure a resident with weight loss was identified, weekly weights were obtained, meal intakes were monitored, and interventions were implemented for 1 of 3 residents with significant weight loss in a sample of 24. (Resident #118)</p> <p>Findings Include:</p> <p>Resident #118's record was reviewed on 4/10/12 at 3:30 p.m. Resident #118's diagnoses included, but were not limited to, dementia, depression, and osteoarthritis.</p> <p>A care plan, dated 2/24/12, indicated "...Potential for wt (weight) loss R/T (related to) Dx (diagnosis) of dementia leaves 25% or more meal uneaten...monitor acceptance...wkly (weekly) wts (weights)..."</p>	F0325	F325 -D 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. On 4/10/12 physician was notified of resident's weight loss and resident was on Med-pass as of 4/5/12b. Resident is an extremely slow eater and table mates leave quickly. Resident's table changed to accommodate her assistance in eating.c. Resident #118 weekly weights and med-pass continue. 1:1 training provided to staff nurses to ensure that any changes in resident weight require immediate physician notification and documentation in the resident's record. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. Anyone has the potential to be affected by weight loss.b. A chart audit was completed on all residents' potential weight loss. The	05/04/2012			

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	<p>The resident's weight record indicated the resident's weight in February 2012 was 103 pounds.</p> <p>A nutritional progress note, dated 2/25/12, indicated "...readmit wt 102# (pounds) ...weight gain desirable...monitor wts and intakes..."</p> <p>A physician's order, dated 3/10/12, indicated "weekly weights..."</p> <p>The resident's, March 2012, treatment record indicated the resident weight on 3/18/12 was 94 pounds. This was a 10% weight loss from the February 2012 weight of 103 pounds. There was not a weight on 3/25/12.</p> <p>The resident's next weight was on 4/5/12 was 94 pounds.</p> <p>Review of the nurses' notes lacked documentation to indicated the physician had been notified of the resident's weight loss until 4/5/12.</p> <p>A nutritional progress note, dated 4/5/12, indicated "RD (Registered Dietician) Note:...monthly wt 98# to be rechecked....Recommend increase med pass (supplement) to 90 ml (milliliters) QID (four times a day)..."</p>		<p>physician was notified as indicated. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Re-education of staff related to importance of completing weekly weights if required and following the documentation procedure accordingly including physician and family notification.b. Re-education regarding meal consumption process. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.a. DON/designee to audit all residents with weekly weights for three months, then 50% of residents with weekly weights for three (3) months and report results to QA meeting monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.b. DON/designee to audit all food consumption records for accuracy daily for one month, then three times a week for one month, then twice a week for two months and once per week for 2 months. All results to be reported to QA meeting monthly for total of six months. . If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct</p>				

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	<p>The resident's food consumption records, dated 3/12, indicated on March 9,10,11,12, and 13 there was a lack of documentation of how much the resident had consumed for dinner. On March 28, there was a lack of documentation of what the resident consumed at breakfast and lunch, and the resident had refused supper. On March 29 there was a lack of documentation of what the resident had consumed for breakfast, lunch, and dinner. On 3/31 there was a lack of documentation of what the resident had eaten for lunch or dinner.</p> <p>The resident's food consumption record, dated 4/12, indicated on 4/1 through 4/3 there was a lack of documentation what the resident had eaten at breakfast and lunch. On 4/6/12 there was a lack of documentation of what the resident had eaten at breakfast. On 4/9/12 there was a lack of documentation of what the resident had consumed for breakfast and lunch. The record lacked documentation of what the resident had eaten at supper from 4/1/12 through 4/09/12.</p> <p>During an interview on 4/10/12 at 4:45 p.m., the Eden Unit Manager indicated the physician was not notified of the weight loss until 4/5/12. She indicated the resident was not weighed weekly. She</p>		and recommend continued monitoring until corrections are effective.c. DON/designee will perform an audit involving very readmission to assess for weight loss and to ensure timely physician notification for six months. Reports of the audits will be reported to the QA meeting monthly for six months. The quality assurance committee will review findings monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.	

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	<p>indicated the resident had been weighed on 3/18 and was 94 pounds and then weighed again on 4/5/12 and was 94 pounds. She indicated the resident was on the Reclaim unit when the order for the weekly weights was received and she was not aware of the order when the resident had transferred back to the Eden unit. She indicated it was too long of a time period for the physician to be notified. She indicated they had gotten an order to increase the med pass supplement on 4/5/12.</p> <p>During an interview on 4/11/12 at 9:55 a.m., the Eden Unit Manager indicated the CNA's are responsible for documentation of the food intakes. She indicated she was responsible to ensure the forms were being completed.</p> <p>A facility policy, dated 10/3/11, provided by the Administrator as current, indicated "It is the policy...that staff will identify residents at risk for weight loss to assess and describe prevention activities to address the risk, and provide an individualized plan to intervene when significant unintended weight loss occurs...Assess and evaluate weights for significant and insidious weight loss...Residents who are identified at being at risk for weight loss, will have individual interventions addressed on</p>			

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	their care plan..." 3.1-46(a)(1) 3.1-46(a)(2)				

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F0328 SS=E	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident's oxygen was being administered as ordered by the attending physicians for 2 of 5 residents' with oxygen orders and failed to assess residents' PICC (peripherally inserted central catheters) (intravenous catheters) lines for 2 of 3 resident's with PICC lines in a sample of 24. (Resident's #22, #23, #51, and #55)</p> <p>Findings include:</p> <p>1. Resident #23's record was reviewed on 04/11/12 at 1:45 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus.</p> <p>The admission orders, dated 03/23/12, indicated the resident had a PICC line.</p> <p>The resident's Admission Nursing Evaluation form and nurses' notes, dated 03/23/12, lacked</p>	F0328	<p>F328 –E 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. On Resident #22, #23 and #24 as of 4/16/12 and 4/17/12 they no longer have a PICC line. Both nurses caring for these residents received re-education related to proper documentation on admission and daily for residents with PICC lines. b. For Resident #51 # 55 the oxygen was corrected to proper setting on 4/9/12. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. At this time there are no residents with PICC lines in place. b. On 4/9/12 all residents with oxygen were checked for proper settings related to physician order. 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>	05/04/2012

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	<p>documentation to indicate the resident had a PICC line.</p> <p>The resident's care plans, dated 03/23/12, 04/04/12, and 04/12/12, lacked documentation to indicate the resident had a care plan for the PICC line.</p> <p>The PICC Line Care Protocol Record, dated 03/12, indicated the PICC had been inserted on 03/21/12, and the upper arm circumference was measured on 03/24/12, 03/27/12, and 03/30/12.</p> <p>The PICC Line Care Protocol Record, dated 03/12, indicated the external tubing measurement was to be measured upon admission, weekly, and as needed. The first measurement was documented on 03/30/12.</p> <p>During an interview on 04/11/12 at 2:30 p.m., the Reclaim Unit Manger indicated the PICC line should have been assessed upon admission.</p> <p>2. Resident #22's record was reviewed on 04/10/12 at 11:10 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and hypertension.</p> <p>The resident's physician's admission orders, dated 03/06/12, indicated the resident had a PICC line in her right arm, which was placed on 03/01/12.</p> <p>The Admission Nursing Evaluation and admission nurses' note, dated 03/06/12 at 3:20 p.m., lacked documentation to indicate the resident had PICC line and had an assessment of the PICC line.</p> <p>A nurses' note, dated 04/03/12 at 5:30 a.m., indicated the PICC line was partially pulled out and had received orders to remove the PICC line.</p>		<p>a. Re-education for all nursing staff related to admission assessment and documentation of residents with PICC lines in addition to completion of treatment administration record.</p> <p>b. Re-educate nursing staff related to assuring that oxygen is delivered per physician order. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. a. Will audit any new resident admitted with PICC weekly to ensure proper procedures are being followed, for a total of six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective. b. DON/designee will audit physician order against liter flow for oxygen three times a week or one month, two times per week for one month, then one time per week for one month, every other week by one month and monthly for two months. Reports of the audits will be reported to the QA meeting for six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance</p>	

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	<p>A nurses' note, dated 04/03/12 at 2:50 p.m. (9 hours later), indicated the PICC line had been removed and was measured. The nurses' note lack documentation to indicate the tip of the PICC line was intact.</p> <p>The nurses' notes, dated 04/05/12 at 9 p.m., indicated a PICC line had been reinserted at the hospital. The notes lacked documentation of an assessment, measurements of the external tubing, and arm circumference being completed upon the return of the resident from the hospital.</p> <p>The PICC Line Care Protocol Record, dated 04/05/12, lacked documentation to indicate the arm circumference and external tubing measurement. The form indicated the arm circumference was to be measured every three days and had not been completed.</p> <p>During an interview on 04/10/12 at 12:15 p.m., the Reclaim Unit Manager indicated the PICC had not been assessed. She indicated the arm circumference had not been measured every three days.</p> <p>An undated and untitled, facility policy, received from the Assistant Director of Nursing as current on 04/10/12 at 5:30 p.m., indicated, "...licensed staff will follow procedure for PICC line care per physician orders...c. Refer to PICC line Care Protocol Record Sheet for:...v. Arm Circumference vi. External Tubing Measurement."</p> <p>3. Resident #51 was observed on 04/09/12 at 12:15 p.m. sitting in her wheelchair in the dining room. Her portable oxygen was set at 2.5 liters.</p> <p>Resident #51 was observed on 04/09/12 at 1:45 p.m. sitting in her wheelchair in therapy. Her portable oxygen was set at 2.5 liters.</p>		Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.	

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	<p>During an interview on 04/09/12 at 1:45 p.m., LPN #7 indicate the resident's oxygen was set at 2.5 liters and should have been set on 2 liters.</p> <p>Resident #51's record was reviewed on 04/09/12 at 12:45 p.m. The resident's diagnoses included, but were not limited to, pneumonia and congestive heart failure.</p> <p>The physician's recapitulation orders, dated 04/12, indicated an order for oxygen at 2 liters.</p> <p>4. During an observation on 04/12/12 at 8:50 a.m., Resident #55 was lying in bed, the oxygen was being administered at 1 liter.</p> <p>During an observation on 04/12/12 at 9:50 a.m. with LPN #8 present, Resident #55 was lying in bed, LPN #8 indicated the resident's oxygen was set at 1.5 liters. She indicated the concentrator was not working correctly.</p> <p>Resident #55's record was reviewed on 04/12/12 at 9:05 a.m. The resident's diagnoses included, but were not limited to, hypertension and stroke.</p> <p>The physician's recapitulation orders, dated 04/12, indicated an order for oxygen to be administered at 4 liters.</p> <p>3.1-47(a)(2) 3.1-47(a)(6)</p>			

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F0329 SS=D	<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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to adequately monitor a medication, related to not obtaining a valporic acid (seizure medication) blood level for 1 of 23 residents reviewed for medication monitoring in a total sample of 24. (Resident #113)</p> <p>Findings include:</p> <p>Resident #113's record was reviewed on 4/11/12 at 1:20 p.m. Resident #113's diagnoses included, but were not limited</p>	F0329	F329 –D 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident #113 – The physician was notified on 4/10/12 that the valporic acid level had not Been done in February or March. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. All admissions and intrafacility transfers charts will be audited to ensure lab orders and the results	05/04/2012

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	<p>to, seizure disorder, COPD (chronic obstructive pulmonary disease), and dementia.</p> <p>The physician's recapitulation orders, dated 04/12, indicated an order for Valporic Acid 500 milligrams twice daily for seizures, originally ordered on 01/16/12.</p> <p>A physician's order recapitulation, dated 3/12, indicated to obtain a valporic acid (medication for seizure disorder) level monthly.</p> <p>The resident's record lacked documentation of a valporic acid level after January 2012.</p> <p>During an interview on 4/12/12 at 9:15 a.m., the Eden Unit Manager indicated the resident had returned from the hospital in January with the order for the monthly valporic acid level. She indicated she was unable to find the laboratory requisition to notify the laboratory to draw the valporic acid levels. She indicated the valporic acid levels had not been done in February or March.</p> <p>3.1-48(a)(3)</p>		<p>of ordered labs are present and the physician notified. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Nursing staff will be reeducated on lab ordering process 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:i.e., what quality assurance program will be put into place. a. RCC/designee will audit lab book daily and check medical record to ensure lab report is present and physician has been notified for one month, every other week for two months and monthly for three months for a total of six months. Audit findings will be presented to the QA meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>		

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F0365 SS=D	<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.</p> <p>Based on observation, record review, and interview, the facility failed to provide food in a prepared form to meet the resident's individual needs, related to thickened fluids for 1 of 4 residents with thickened fluids orders reviewed for dietary needs in a total sample of 24. (Residents #70)</p> <p>Findings include:</p> <p>During an observation on 04/09/12 at 12:20 p.m., Resident #70 was in the dining room. The resident was drinking a cup of soup with a thin broth. The resident was coughing. The menu card indicated the resident required nectar thick fluids.</p> <p>During an interview on 04/09/12 at 12:21 p.m., CNA #13 indicated the resident's soup was not thickened.</p> <p>During an interview on 04/09/12 at 12:24 p.m., Dietary Aide #14 indicated the soup had not been thickened.</p> <p>Resident #70's record was reviewed on</p>	F0365	<p>F365 -D</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. On 4/9/12 all scheduled staff immediately re-educated regarding Policy on Consistency Modifications related to diet. Resident #70 was assessed to determine that he had no ill effects as result of non-thickened soup.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents with physician order for thickened liquids have the potential to be affected by this practice.</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>a. Prior to serving thickened soup the nursing staff will evaluate the broth for proper consistency. b. Dietary consultant (see attached) re-educated dietary staff regarding preparation and proper consistency of thickened liquids.</p>	05/04/2012

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	<p>04/10/12 at 11:25 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>The admission physician's orders, dated 03/14/12, indicated an order for nectar thickened liquids.</p> <p>A care plan, dated 03/18/12, indicated the resident was on a therapeutic diet. The approaches included nectar thick liquids.</p> <p>A facility policy, dated 2007 and revised 04/11, titled "Consistency Modifications", received from the Administrator as current, indicated, "...Packets are made available to thickened (sic) soup and coffee..."</p> <p>3.1-21(a)(3)</p>		<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. Dietary manager/designee will audit the fact that thickened liquids are proper consistency every meal, for a total of six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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F0371 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</p> <p>Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions related to dirty microwaves, a dirty stove, expired food and supplements for 1 of 3 units (Eden) and 1 of 1 Activity Room. These practices had the potential to affect 130 of 130 residents who reside in the facility and have the potential to utilize the rooms. (Restorative Nursing Room, Activity Room, Blue Dining Room, D hall storage/supply room)</p> <p>Findings include:</p> <p>During the environmental tour on 4/11/12 from 1:10 p.m. through 3:00 p.m. with the Maintenance Director and Housekeeping Director, the following was observed:</p> <p>Eden Unit</p> <p>1. The inside of the microwave in the Blue Dining Room was dirty with food splatters on the sides and top.</p>	F0371	<p>F371 – F 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. 4/11/12 all microwaves and therapy stove were immediately inspected and cleaned accordingly b. 4/11/12 all expired food/supplements were discarded immediately. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. All residents have the potential to be affected by this 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: a. All staff re-educated to maintain microwaves and stoves in a manner to maintain food under sanitary conditions. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. a. Department head/designee will audit the cleanliness of microwaves and stove daily until</p>	05/04/2012

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	<p>During an interview at the time of the observation, the Housekeeping Director indicated, "Housekeeping is suppose to clean it We will get it clean right now."</p> <p>2. In the D Hall storage/supply room, there were 2 of 2 cans of Osmolite 1.2 (liquid supplement) with expiration dates of 4/1/12.</p> <p>A. Activity Room</p> <p>1. The inside of the microwave was dirty with food splatters on the sides and top.</p> <p>During an interview at the time of the observation, the Housekeeping Director indicated, "Activities is responsible for cleaning this microwave."</p> <p>2. In a cabinet, a bottle of light corn syrup had a written date of 11/07 and a sell by date of 12/25/07.</p> <p>B. Restorative Nursing Room</p> <p>1. The stove was dirty with dust and debri.</p> <p>During an interview at the time of the observation, the Housekeeping Director indicated, "Therapy uses it. They are suppose to clean it."</p>		<p>compliance is achieved, for a total of six months. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>	

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	3.1-21(i)(1)			

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview, the facility failed to administer medications as ordered by the resident's physician, for 1 of 24 residents reviewed for medications in a total sample of 24. (Residents #7)</p> <p>Findings include:</p> <p>Resident #7's record was reviewed on 04/10/12 at 9:35 a.m. The resident's diagnoses included, but were not limited to, arthritis and dementia.</p> <p>The physician's recapitulation orders,</p>	F0425	F 425 – D 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident #7 – The physician was notified on 4/10/12 regarding the order for Tylenol which has been dropped off the MAR 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. Resident's MAR's audited for accuracy and completeness to ensure they match physician orders. 3. What measures will be put into place or what systemic changes will be made to ensure	05/04/2012

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	<p>dated 03/12, indicated orders for acetaminophen (pain medication) (originally dated 04/17/09) 325 mg (milligrams), two tablets every morning for degenerative osteoarthritis, acetaminophen 325 mg (originally dated 04/17/09) , one tablet every evening and at bedtime, and acetaminophen 325 mg (originally dated 06/27/11), two tablets every four hours as needed for pain.</p> <p>A physician's order, dated 02/22/12, indicated an order to discontinue acetaminophen 650 mg as needed every four hours and to begin acetaminophen 325 mg every six hours as needed for pain.</p> <p>The Medication Administration Record (MAR), dated 04/12, lacked documentation the resident had an order for and received acetaminophen 325 mg, two tablets every morning and one tablet every evening and at bedtime from 04/01/12 through 04/10/12.</p> <p>During an interview on 04/10/12 at 10:30 a.m., the Haven Unit Manager indicated it looked like the pharmacy had dropped the order off the MAR. She indicated the nurse should have found the error when she checked the physician's orders and MARs.</p>		<p>that the deficient practice does not recur: a. Re-educate nursing staff related to checking end of month MAR against new month MAR for accuracy. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:i.e., what quality assurance program will be put into place. a. DON/designee will audit accuracy of the MAR month to month for six months. Audit findings will be presented to the QA meeting monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>	

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	3.1-25(a)			

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F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 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 record review, the facility failed to ensure multi dose vials of insulin were labeled when opened and were discarded when expired</p>	F0431	F 431 – E 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient	05/04/2012			

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	<p>for 1 of 3 medication rooms (Reclaim) and 2 of 6 medication carts (Eden Unit B and C carts). The facility also failed to discard expired eye drops for 1 of 6 medication carts (Haven Unit).</p> <p>Findings include:</p> <p>During an observation on 4/9/12 at 4:30 p.m., with LPN #9 of the Reclaim medication room, the following was observed:</p> <p>1. In the refrigerator there was a vial of Lantus (insulin) that was opened 3/1/12. During an interview at the time of the observation, LPN #9 indicated it should have been discarded because it is only good for 28 days.</p> <p>2. In the refrigerator there was a Novolog flex pen (insulin pen) with a "do not use after date" of 4/6/12. During an interview at the time of the observation, LPN #9 indicated it should have been discarded.</p> <p>During an observation on 4/11/12 at 9 a.m., with LPN #10 of the Eden Unit C hall medication cart, the following was observed:</p> <p>1. A vial of Novolin R (insulin) with an open date of 2/23/12. During an interview at the time of the observation,</p>		<p>practice.</p> <p>a. The expired medication was removed and new medication order for those individuals.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents with multi-dose medication can be affected by this practice..</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>a. Re-educate nursing staff related to dating multi-dose vials when opened and discarding expired medication.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. DON/designee will audit for compliance the medication rooms and medication carts weekly for six months. All audits will be conducted and reported to QA committee monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>				

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	<p>LPN #10 indicated "It is good for 30 days after it is opened, it should have been discarded."</p> <p>2. A vial of Lantus on the open date only had "3/." During an interview at the time of the observation, LPN #10 indicated she was not sure when it was opened and was going to discard it.</p> <p>3. An unopened vial of Novolog (insulin) indicated "refrigerate until opened." During an interview at the time of the observation, LPN #10 indicated the vial should have been in the refrigerator and it was all of the nurses responsibility to check the medication carts for expired medications.</p> <p>During an observation on 4/12/12 at 9:20 a.m., with LPN #11 of the Eden Unit B hall medication cart, the following was observed:</p> <p>1. There were 2 vials of Lantus and 1 vial of Novolog without open dates.</p> <p>2. A vial of Novolin R with an open date of 2/2/12 and "do not use 30 days after above date." During an interview at the time of the observation, LPN #11 indicated "I will get rid of all of these and order new."</p>				

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	<p>During an observation on 4/12/12 at 9:40 a.m., with LPN #12 of the Haven Unit medication cart, the following was observed:</p> <p>1. A bottle of Xalatan ophthalmic solution (eye drops) with an open date of 12/31/11. At the time of the observation, LPN #12 called the pharmacy and indicated "they are only good for 6 weeks once they are opened." She indicated she was going to reorder more.</p> <p>Information provided by the pharmacy, received on 4/12/12 at 3:20 p.m. by the Compliance Coordinator, indicated "Medications with Shortened Expiration Dates...Insulin: Humulin, Humalog, Novolog, Lantus...Vials expire 28 days after opening/puncturing...Insulin: Novolin...Vials expire 30 days after opening/puncturing...Xalatan...Once a bottle is opened for use it may be stored at room temperature...for six weeks...General Guidelines: The opened date should be noted on each container/vial of medication..."</p> <p>3.1-25(m)</p>			

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F0441 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>A. Based on record review and interview, the facility failed to ensure a second step</p>	F0441	1. What corrective action (s) will be accomplished for those residents found	05/04/2012			

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	<p>mantoux was completed for 1 resident in a sample of 24 residents reviewed for mantoux's. (Resident #42)</p> <p>B. Based on observation, record review, and interview, the facility failed to ensure a dressing change was completed to prevent the potential for cross contamination of the areas, related to cleansing the wounds and measuring of the wounds for 3 of 3 dressing changes observed for 3 of 3 residents with dressing changes in a total sample of 24. (Resident #60, #70, #94. LPN #10, the ADoN (Assistant of Nursing), and the Eden Unit Manager)</p> <p>Findings include:</p> <p>1A. Resident #42's record was reviewed on 04/10/12 at 2:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. The resident was admitted into the facility on 02/22/12 and readmitted on 03/12/12.</p> <p>The resident had a first step mantoux given on 02/22/12 and read on 02/25/12. The resident's record lacked documentation to indicate a second step mantoux had been given.</p> <p>During an interview on 04/10/12 at 3:50 p.m., the Reclaim Unit Manager indicated</p>		<p>to have been affected by the deficient practice.</p> <p>a. Resident #42 two-step TB was initiated on 4/27/12 and the second step scheduled for 5/9/12</p> <p>b. Resident # 60, #70 and #94 had no adverse consequences from the wound cleansing and measuring device.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents with wounds have the potential to be affected by this practice.</p> <p>b. All residents requiring TB testing have the potential to be affected by this practice.</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>a. Re-educate nursing staff related to potential cross contamination of open areas</p> <p>a. Utilize separate measuring device for each open area</p> <p>b. Use of separate gauze pads for each area</p> <p>b. Re-educated nurses regarding proper procedure for residents requiring 2 Step TB test.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient</p>	

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	<p>a second step mantoux had not been completed.</p> <p>1B. Observation on 4/11/12 at 9:50 a.m. of a dressing change to resident #94's pressure ulcers on the left and right buttocks indicated the following: the ADoN was observed to wipe her hands with alcohol gel and place on gloves. She was observed to use the same plastic measuring tool to measure the pressure ulcers on the left and right buttock. LPN #10 was observed to wipe her hands with alcohol gel and place gloves on her hands. LPN #10 was observed to clean the pressure ulcers with normal saline. LPN #10 was observed to use the same piece of gauze to pat dry the pressure ulcers on the left and right buttocks.</p> <p>Resident #94's record was reviewed on 4/10/12 at 12:10 p.m. Resident #94's diagnoses included, but were not limited to, diabetes mellitus and dementia.</p> <p>The physician's telephone order, dated 4/4/12 indicated to cleanse area the left and right gluteus with "normal saline, apply santyl (wound debridement ointment), aquacel (medicated gauze), duoderm (wound covering) daily."</p> <p>During an interview on 4/11/12 at 10:10 a.m., the ADoN indicated she should have</p>		<p>practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>a. Compliance nurse/designee will audit for separate measuring device and gauze for each wound during dressing changes. Audit will involve observation of one dressing per unit, daily different shifts for two weeks, then three times a week for two months, then one time per week for two months, then every other week for two months. Reports of the audits will be reported to the QA meeting monthly for six months.</p> <p>b. DON/designee will audit all new admission resident records to ensure proper completion of the 2 step TB test for six months. Reports of the audit will be reported to the QA meeting monthly for six months.</p>		

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	<p>used two different measuring tools to measure.</p> <p>During an interview on 4/11/12 at 10:15 a.m., LPN #10 indicated she should not have used to the same piece of gauze on both pressure ulcers.</p> <p>2B. During a dressing change on 4/10/12 at 2:00 p.m., to Resident #60 right buttock and right upper thigh, the Eden Unit Manager was observed to use the same plastic measuring tool to both wounds all the wounds. The resident had 3 wounds to the right buttock and 3 wounds to the right upper thigh.</p> <p>Resident #60's record was review on 4/10/12 at 9:35 a.m. Resident #60's diagnoses included, but were not limited to, congestive heart failure, urinary retention, and arthritis.</p> <p>A physician's order, indicated to cleanse the right buttock with normal saline and apply duoderm and change the dressing on Mondays, Wednesdays and Fridays,</p> <p>During an interview on 4/11/12 at 10:00 a.m., the Eden Unit Manager indicated she should not have used the same measuring tool on all the areas.</p> <p>3B. Resident #70's record was reviewed on 4/10/12 at 11:25 a.m. Resident #70's</p>						

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	<p>diagnoses included, but were not limited to, severe peripheral vascular disease, dementia, and diabetes mellitus.</p> <p>A physician's order, dated 3/19/12, indicated "...Cleanse area to L (left) outer foot with normal saline apply bactroban (ointment) Santyl (a debriding ointment)...cover c (with) dry dressing daily and prn (as needed)."</p> <p>Resident #70 was observed during a skin assessment, with the Eden Unit Manager on 4/10/12 at 2:35 p.m. The Eden Unit Manager removed a dressing, dated 4/8/12, from the resident's left foot. There were 3 wounds noted to the resident's outer left foot. She then measured the areas with a plastic measuring tool. She used the same plastic measuring tool on all three wounds.</p> <p>During an interview on 4/11/12 at 10 a.m., the Eden Unit Manager, indicated she should not have used the same plastic measuring tool for all three wounds.</p> <p>3.1-18(j)</p>				

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F0465 SS=A	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORT ABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure safe, sanitary conditions related to a broken medication cart and missing cove base for 1 of 3 Units (Reclaim)</p> <p>Findings include:</p> <p>During the environmental tour, on 4/11/12 from 1:10 p.m. through 3:00 p.m. with the Maintenance Director and Housekeeping Director, the following was observed:</p> <p>1. The Reclaim 2 medication cart was broken on the left corner and 2 screws were sticking out. During an interview at the time of the observation, the Maintenance Director indicated he would fix it.</p> <p>2. The column/support beam by the nurses station was missing cove base on 2 sides.</p> <p>3.1-19(f)</p>	F0465	<p>F 465 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. The pharmacy was contacted regarding medication cart and the supervisor stated that this particular cart would be replaced.b. The cove base was replaced on 4/12/12 in the area noted. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. All pharmacy carts were examined to ensure that they are in good repair.b. Housekeeping and maintenance made rounds to ensure all cove base present on the other nursing units. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Staff re-educated related to completion of work order for any medication carts in need of repair or cove base requiring replacement. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. a. Maintenance</p>	05/04/2012	

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			and housekeeping supervisor/designee will perform one environmental audit per week for two months, then one audit every other week for two months, then one every three weeks for two months. All results of audits will be reported to QA monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.	

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure there was at least one staff member with a current first aid and CPR (cardiopulmonary resuscitation) certificate scheduled for night shift for 7 of 11 days of schedules reviewed.</p> <p>Findings include:</p> <p>Review of the nursing staff schedules, dated 04/01/12 through 04/11/12,</p>	R0117	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.a. On 4/9/12 agreement signed with local fire department to ensure that all Assisted Living Staff receive CPR and First Aid certification.2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken.a. On 4/9/12 all Assisted</p>	05/04/2012			

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	<p>received as current by the Director of Nursing (DoN), indicated there were no employees scheduled for duty on night shift, who had both a CPR and a first aid certificate for April 2, 3, 4, 5, 7, 8, and 11, 2012.</p> <p>During an interview on 04/12/12 at 2:35 p.m., the Director of Nursing indicated there was no staff who were first aid certified scheduled.</p>		<p>Nursing staff's records were reviewed to identify the staff who require training in CPR and First Aid.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.a. Copies of CPR and First Aid certification will be placed in a binder in the Assisted Living office in addition to their personal records and the Assisted Living Coordinator will assure that the records are checked periodically to keep the department in compliance.4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.a. The Assisted Living Coordinator /designee will ensure that the current staff will be trained immediately with a report made to the QA committee upon completion.b. The Assisted Living Coordinator/designee will oversee continuous monitoring of the binder which includes copies of staff CPR and first aid certifications to assure they are kept current.c. Any new employee to the area will be required to have CPR and first aid prior to their employment.</p>	