

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2012
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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F0000	<p>This visit was for the Investigation of Complaint IN00107672.</p> <p>Complaint IN00107672 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F225, F226, F282, F309, and F493.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: May 23, 24 & 29, 2012</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Survey team: Mary Jane G. Fischer, RN</p> <p>Census bed type: SNF: 23 SNF/NF: 114 Total: 137</p> <p>Census payor type: Medicare: 17 Medicaid: 106 Other: 14 Total: 137</p> <p>Sample: 11</p> <p>These deficiencies also reflect state</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

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

TITLE

(X6) DATE

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

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 6/4/12 by Jennie Bartelt, RN.				

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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 record review and interview, the facility failed to ensure a resident's family member and physician were notified of a fall with injury. The resident fell and sustained a head injury which included an</p>	F0157	1. The physician for the resident #D was notified of the incident on April 25 th @ 8:00am. Due to no abnormalities noted in the assessment, there were no new orders. When the resident's	06/18/2012			

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	<p>abrasion, the nursing staff failed to immediately notify the resident's physician for the possibility of intervention for 1 of 3 residents reviewed for falls in a sample of 11. [Resident "D"].</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 05-23-12 at 9:50 a.m. Diagnoses included, but were not limited to, confusion, falls, dementia and impulse control disorder. These diagnoses remained current at the time of the record review.</p> <p>The resident's Medication Administration Record indicated the resident had physician orders, dated 12-13-11, for Aspirin [nonsteroidal anti-inflammatory medication] 81 mg [milligrams] by mouth, one time daily, as well as Plavix [anti-platelet medication] 75 mg one capsule daily, ordered 02-28-12.</p> <p>The resident's plan of care indicated, "Notify responsible party and MD [Medical Doctor] if a fall occurs."</p> <p>The nurses notes, dated 04-25-12 at 4:30 [a.m.], indicated the following: "Fall, resident stood up from wheelchair and lost balance. Hit [R] [right] side of</p>		<p>condition began to change the physician was notified again and new orders were obtained to send the resident to the ER for evaluation and treatment. 2. Any resident with a suspected head injury has the potential to be affected. All residents with a potential head injury will be reviewed to ensure the physician was notified per facility policy. Nursing staff will be re-educated on the facility's Physician Notification and Incident & Accident policies, (please see attachment A). 3. As a means to ensure ongoing compliance all incidents and investigations will be reviewed daily in the morning meeting to ensure physician notification has occurred and investigations have been completed per facility policy. The DON or designee will sign each incident report after reviewing it to ensure the physician was notified per facility policy. Should a deficient practice be noted,, immediate corrective action will be taken. As a second check the nurse consultant will review all incident reports to ensure they are complete and accurate at least every two weeks, (please see attachment B). All fall related incidents will be reviewed by the interdisciplinary team during the facility's weekly fall meeting.4. As a means of quality assurance, the DON or designee will review any findings and subsequent corrective action(s) in response to</p>	

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	<p>head. Hematoma with abrasion present. Area cleansed and left open to air. V/S [blood pressure] 120/69, [temperature] 97.7, [pulse] 86, and [respirations] 18."</p> <p>The next nurses note, dated 04-25-12 at 4:00 p.m., indicated "Res. [resident] sent to [name of local area hospital] for eval [evaluation] and tx. [treatment] d/t [due to] fall in A.M. Res. lethargic, c/o [complains of] head pain, leaning to rt. [right] side, not willing to get out of bed. Neuro's [neurological checks] WNL [within normal limits] [blood pressure] 137/80, [temperature] 97.7, pulse] 78, and [respirations] 16. PERRLA <sic> [pupils equals and reactive to light], hand grips - equal. res. alert. [Family member] notified of fall et [and] send <sic> to [name of local area hospital]."</p> <p>Review of the facility "Incident & Accident Report and Investigation," dated 04-25-12, prompted the nurse with the question, "If it is known or suspected that resident hit head or face, is the resident taking a medication that thins the blood or can contribute to bleeding," was blank.</p> <p>A subsequent question prompted the nurse, "If 'yes' [in reference to the above question], has the physician been informed and has the medication been held or lab tests ordered?" This part of</p>		the ongoing monitoring, in the facility's quarterly Quality Assurance meeting.				

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	<p>the report and investigation was also left blank.</p> <p>The report indicated the resident complained of pain; however, the section of the report which prompted the nurse to "explain" was left blank and if treatment or relief was provided.</p> <p>The Medication Administration Record indicated the resident received the two medications, Aspirin and Plavix, on 04-25-12, which could contribute to bleeding activity, after the fall.</p> <p>The hospital discharge summary, dated 05-08-12, indicated the resident "sustained an unwitnessed fall on the day prior to admission. [Resident] was found on the floor with complaints of headache and hip pain. [Resident] was brought to the emergency department for evaluation where a CT scan revealed a 'large' left sided subdural hematoma with temporal contusion and an interventricular hemorrhage."</p> <p>During an interview on 05-24-12 at 1:00 p.m., the Unit Manager, licensed nurse employee #6, indicated the resident started to "change" in the early afternoon [04-25-12] and then by 3:00 p.m. or so, it was around change of shift that "we noticed [resident] began to lean while</p>			

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	<p>seated in the wheelchair and was difficult to get a response. We notified the doctor and got orders to send [resident] to the hospital."</p> <p>The facility policy, reviewed on 05-24-12 at 12:35 p.m., titled "Incident & Accident Report," dated as revised 01/08, indicated the following:</p> <p>"Purpose: To document all incidents and accidents occurring involving resident, employees or visitors."</p> <p>"Procedure: 1. Resident * Provide emergency care & complete assessment * Initiate Incident & Accident Report and Investigation form * Notify physician per policy and document * Notify resident's responsible party per policy and document."</p> <p>Review of the facility policy on 05-24-212 at 12:35 p.m., titled "Physician & Family Notification Procedure," and dated 01-06, indicated the following:</p> <p>"Purpose: To keep the physician, resident and family appraised <sic> of all condition changes."</p> <p>"Procedure: Telephone 1. Telephone</p>			

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	<p>notification is required for all emergencies or all [bold type] condition changes that require an immediate response. 2. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan. 3. Notify the primary physician during regular office hours and the on-call or alternate physician during closed office hours or when the physician is not available."</p> <p>This federal tag relates to Complaint IN00107672.</p> <p>3.1-5(a)(1)</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 record review and interview, the facility failed to investigate and report</p>	F0225	1. Resident #D was assessed and an investigation completed which concluded that the bruising	06/18/2012			

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	<p>bruising of unknown source, in that when a resident was noted with bruising, the facility failed to investigate the circumstances related to the bruising for 1 of 3 residents reviewed for injuries in a sample of 11. [Resident "D"]</p> <p>Findings include:</p> <p>1. The record for Resident "D" was reviewed on 05-23-12 at 9:50 a.m. Diagnoses included but were not limited to confusion, falls, dementia and impulse control disorder. These diagnoses remained current at the time of the record review. The resident medication administration record indicated the resident had physician orders, dated 12-13-11 for Aspirin (non-steroidal anti-inflammatory) 81 mg [milligrams] by mouth, one time - daily as well as Plavix (platelet aggregation inhibitor) 75 mg one capsule daily ordered 02-28-12.</p> <p>The Minimum Data Set assessment, dated 03-09-12, indicated the resident required extensive assistance with transfer, ambulation, hygiene and toileting.</p> <p>Nurses notes, dated 04-02-12, 12:30 p.m., indicated the following: "When toileting resident, this writer noted bruise, purple and blue in color, measuring 13 by 6 cm [centimeters] on</p>		<p>was potentially related to her past fall. The size of the bruising did not meet the facility's reporting criteria as it was less than 10 centimeters by 10 centimeters in size. The physician and responsible party were notified per facility policy. 2. All residents with bruising of unknown origin have the potential to be affected. All residents have a head to toe assessment completed at least weekly. Any bruising of unknown origin noted will have an investigation completed per facility policy. All nurses re-educated on addressing injuries of unknown origin, (please see attachment A). 3. As a means to ensure ongoing compliance the DON or designee will review 24 hour report daily on regularly scheduled days as evidenced by initialing the 24 report form. The DON or designee will ensure any reports of injury of unknown origin will be investigated, (please see attachment C. Should a deficient practice be noted, immediate corrective action will be taken. 4. As a quality measure the DON or designee will review any findings and subsequent corrective action(s) in response to the ongoing monitoring, in the facility's quarterly Quality Assurance meeting.</p>				

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	<p>right lateral thigh. No swelling noted. Res. [resident] had a fall on 03-26-12 without bruising at that time. Res. c/o pain to right hip on 03-27-[12]. X-ray ordered per MD [Medical Doctor] without evidence of fx. [fracture] Pain managed at this time."</p> <p>2. Review of facility policy on 05-24-12 at 3:00 p.m., titled "REPORTING UNUSUAL OCCURRENCES TO THE STATE [bold type and underscored], dated as revised 02-10, indicated the following:</p> <p>"The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source ... are reported immediately to the Administrator of the facility and to other officials as applicable."</p> <p>3. Review of facility policy on 05-24-12 at 3:00 p.m., titled "Reporting of Large Areas of Contusion [bold type] indicated the following:</p> <p>"POLICY [bold type and underscored]: This facility shall utilize its policy to determine those occurrences to be deemed reportable to ISDH. In that the policy states "large areas of contusions (greater than or equal to 5 centimeters by 5</p>			

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	<p>centimeters on the resident's face or equal to 10 centimeters by 10 centimeters on other areas of the body) shall be considered a large contusion and reportable to ISDH... ."</p> <p>"PROCEDURE [bold type and underscored] - 1. Should a large area of contusion be observed/reported, necessary investigation shall be initiated to determine the potential causal factor(s) of the said injury. 2. Initial notification will be made to applicable agencies by the Administrator of his/her designee upon determining that the contusion as reportable per the above listed facility definition which has been approved by the facility Medical Director. 3. The results of the investigation will be forwarded to the division with the initial report (if information available) or within five (5) working days of the reporting of the large area of contusion."</p> <p>4. During interview on 05-23-12 at 2:00 p.m., the Administrator indicated the bruising was not investigated or reported because it did not meeting the facility requirements. However during further interview the Administrator indicated that if the resident fell on 03-26-12 the bruising should have been apparent earlier than 8 days after the incident.</p>			

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	This federal tag relates to Complaint IN00107672. 3.1-28(c)				

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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 record review and interview, the facility failed to follow its policy for investigation and reporting bruising of unknown source, in that when a resident was noted with bruising, the facility failed to investigate the circumstances related to the bruising for 1 of 3 residents reviewed for injuries in a sample of 11. [Resident "D"]</p> <p>Findings include:</p> <p>1. The record for Resident "D" was reviewed on 05-23-12 at 9:50 a.m. Diagnoses included, but were not limited to, confusion, falls, dementia and impulse control disorder. These diagnoses remained current at the time of the record review. The resident medication administration record indicated the resident had physician orders, dated 12-13-11 for Aspirin (non-steroidal anti-inflammatory) 81 mg [milligrams] by mouth, one time - daily as well as Plavix (platelet aggregation inhibitor) 75 mg one capsule daily ordered 02-28-12.</p>	F0226	<p>1. Resident #D was assessed and an investigation completed which concluded that the bruising was potentially related to her past fall. The size of the bruising did not meet the facility's reporting criteria as it was less than 10 centimeters by 10 centimeters in size. The physician and responsible party were notified per facility policy. 2. All residents with bruising of unknown origin have the potential to be affected. All residents have a head to toe assessment completed at least weekly. Any bruising of unknown origin noted will have an investigation completed per facility policy. All nurses re-educated on addressing injuries of unknown origin, (please see attachment A). 3. As a means to ensure ongoing compliance the DON or designee will review 24 hour report daily on regularly scheduled days as evidenced by initialing the 24 report form. The DON or designee will ensure any reports of injury of unknown origin will be investigated, (please see attachment C). Should a deficient practice be noted, immediate corrective action will be taken.4.</p>	06/18/2012	

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	<p>The Minimum Data Set assessment, dated 03-09-12, indicated the resident required extensive assistance with transfer, ambulation, hygiene and toileting.</p> <p>Nurses notes, dated 04-02-12, 12:30 p.m., indicated the following: "When toileting resident, this writer noted bruise, purple and blue in color, measuring 13 by 6 cm [centimeters] on right lateral thigh. No swelling noted. Res. [resident] had a fall on 03-26-12 without bruising at that time. Res. c/o pain to right hip on 03-27-[12]. X-ray ordered per MD [Medical Doctor] without evidence of fx. [fracture] Pain managed at this time."</p> <p>2. Review of facility policy on 05-24-12 at 3:00 p.m., titled "REPORTING UNUSUAL OCCURRENCES TO THE STATE [bold type and underscored], dated as revised 02-10, indicated the following: "The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source ... are reported immediately to the Administrator of the facility and to other officials as applicable."</p> <p>3. Review of facility policy on 05-24-12</p>		As a quality measure the DON or designee will review any findings and subsequent corrective action(s) in response to the ongoing monitoring, in the facility's quarterly Quality Assurance meeting.				

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	<p>at 3:00 p.m., titled "Reporting of Large Areas of Contusion [bold type] indicated the following:</p> <p>"POLICY [bold type and underscored]: This facility shall utilize its policy to determine those occurrences to be deemed reportable to ISDH [Indiana State Department of Health]. In that the policy states "large areas of contusions (greater than or equal to 5 centimeters by 5 centimeters on the resident's face or equal to 10 centimeters by 10 centimeters on other areas of the body) shall be considered a large contusion and reportable to ISDH... ."</p> <p>"PROCEDURE [bold type and underscored] - 1. Should a large area of contusion be observed/reported, necessary investigation shall be initiated to determine the potential causal factor(s) of the said injury. 2. Initial notification will be made to applicable agencies by the Administrator of his/her designee upon determining that the contusion as reportable per the above listed facility definition which has been approved by the facility Medical Director. 3. The results of the investigation will be forwarded to the division with the initial report (if information available) or within five (5) working days of the reporting of the large area of contusion."</p>			

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	<p>4. During interview on 05-23-12 at 2:00 p.m., the Administrator indicated the bruising was not investigated or reported because it did not meeting the facility requirements. However during further interview the Administrator indicated that if the resident fell on 03-26-12 the bruising should have been apparent earlier than 8 days after the incident.</p> <p>This federal tag relates to Complaint IN00107672.</p> <p>3.1-28(a)</p>			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure and provide social service intervention, in that when a resident was assessed as a "smoker" the facility failed to ensure the resident was supervised with smoking activities and smoking paraphernalia or social service intervention to monitor the resident's manipulative and unsafe behaviors for 1 of 2 residents identified as a smoker who needed supervision in a sample of 11. [Resident "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 05-23-12 at 10:25 a.m. Diagnoses included, but were not limited to, squamous cell carcinoma - cervical with metastasis, behavior issues, history of depression, anxiety, chronic obstructive pulmonary disease, and borderline personality disorder. These diagnoses remained current at the time of the record review.</p> <p>The "Mood and Behavior Communication Memo's" indicated the following</p>	F0250	<p>1. Resident #C has been promptly re-educated on the facility's smoking policy each time non-compliance was noted. The physician is aware of resident #C's non-compliance. One should note resident #C is her own responsible party. There is a smoke detector in her room and her room was checked to ensure there were no smoking materials. A behavior contract has been completed between the facility and resident #C.</p> <p>2. The facility has identified all of the residents that smoke as well as the residents who have been non-compliant with the facility's smoking policy. All residents that choose to smoke have been educated on and signed the facility's smoking policy. A smoking assessment has been completed on all residents that smoke to ensure appropriate interventions are in place as to promote resident safety which are care planned as well. Smoke detectors have been placed in the rooms of residents who have been non-compliant, if not already in place. Staff will be re-educated on the facility's smoking policy including handling of smoking paraphernalia and behavior</p>	06/18/2012	

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	<p>infractions related to the facility smoking policy:</p> <p>"04-03-12 - (time not documented) cigarettes found and lighter on person. pt. [patient] [Resident "C"] education given on facility policy and stated understood supervisor 3 - 11 aware." This behavior memo was completed by licensed nurse, employee #16.</p> <p>"04-12-12 at 2:20 p.m. - Resident ["C"] was smoking with another resident that had not lit cigarette yet. Went out to tell them it was not smoking time. When I asked for the lighter and ciggerrets <sic> [resident] started raising voice. They both were willing to come back in but were not willing to give lighter or ciggerettes <sic> to me." This behavior memo was completed by activity staff member, employee #14.</p> <p>"04-14-12 at 9:30 a.m. [Resident "C"] was wanting me [employee receptionist #13] to give a pack of cigarettes and was upset that I wouldn't. [Resident "C"] kept saying [resident] only had 2 to 3 months to live. I gave [Resident "C"] 2 cigarettes and I shouldn't have done that." This behavior memo was completed by the Receptionist, employee #13.</p> <p>"04-23-12 at 12:00 a.m. and 2:00 a.m. -</p>		<p>monitoring, (please see attachment A).</p> <p>3.As a measure to ensure ongoing compliance the SSD or designee will complete room checks daily on the residents who have exhibited non-compliant behaviors related to the smoking policy, (please see attachment D). Smoking assessments will be completed by Social Services at least quarterly and with any significant change in condition. The SSD or designee will review all behavior memos daily in the morning meeting to ensure appropriate interventions implemented promptly. The SSD or designee will complete follow up documentation to address each behavior exhibited. The unit managers will read nurses notes to ensure all items documented are addressed per facility policy daily on regularly scheduled days and initial upon review, (please see attachment C). Additionally the DON or designee will review the nurses notes daily on regularly scheduled days as a second check to ensure all issues are addressed appropriately. Should a deficient practice be observed, immediate corrective action will be taken.</p> <p>4.As a measure of quality assurance the SSD or designee and DON or designee will review any findings and subsequent corrective action(s) in response to the ongoing monitoring, in the facility's quarterly Quality</p>				

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	<p>Resident ["C"] outside smoking at midnight with [name of another resident's family members]. Tried to convince me to smoke with them so [Resident "C"] could stay out. Said [Resident "C"] will be in when [resident] is done. At 2:00 a.m. [Resident "C"] attempted to go out again to smoke saying we don't know [Resident "C"] pain. I told [Resident "C"] was not to go out [Resident "C"] finally turned around and started to cry." This behavior memo was completed by CNA [Certified Nurses Aide], employee #15</p> <p>"05-17-12 Resident ["C"] was found outside courtyard by the chapel smoking, staff went and ask <sic> Resident ["C"] to come in because staff needed to supervise [Resident "C"] (8:15 p.m.) Resident ["C"] came in without incident then at 8:35 p.m. while staff was on lunch CNA came to let me know that resident was in church parking lot smoking. Went to see had LOA [leave of absence] book been signed and it wasn't. Staff asked resident to come in and [Resident "C"] stated [Resident "C"] signed LOA book and remained outside...." This communication was signed by licensed nurse, employee #16.</p> <p>The record contained an assessment dated 03-30-12 in which the resident was identified as "alert and oriented" and</p>		Assurance meeting.		

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	<p>recommendations for "smoking with supervision (facility policy)." In addition, the facility smoking policy, contained within the record, signed and dated 03-30-12, indicated the resident was made aware of the facility smoking policy.</p> <p>During interview on 05-24-12 at 3:05 p.m., the Unit Manager, licensed nurse employee #6, indicated the problems/concerns with the resident's non-compliance with the facility smoking policy continued. She indicated, "Today [Resident "C"] was found with 6 cigarettes found hidden underneath the cushion on [resident] wheelchair."</p> <p>2. The facility policy, dated 12-19-11, indicated, "The policy of this facility that the safety of all residents, whether he/she smokes or not, will be ensured. This care center will be a smoke free building with the exception of the following areas: main lounge court yard [bold type]."</p> <p>The facility smoking policy included the following steps for safe smoking:</p> <p>* Designated smoke times - 6:30 a.m., 10:00 a.m., 2:30 p.m., 7:00 p.m. and 10:30 p.m.</p> <p>* Staff will educate residents on the following, but not limited to: 4. Storage</p>			

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	<p>of smoking items, 5. Violation of facility smoking policy.</p> <p>* Smoking sessions will be supervised by a staff member only.</p> <p>* All smoking materials will be kept at the A-wing nurse's station. Smoking material will be distributed by a staff member.</p> <p>* Families/responsible parties will be instructed that all smoking materials must be brought to the nurse's station and will be distributed by staff.</p> <p>* Resident may not have cigarettes or lighters in their possession.</p> <p>The facility has the right to:</p> <p>* implement a behavioral contract, which will specify conduct and obligations of the resident.</p> <p>* Contact the ombudsman and schedule a formal meeting with the interdisciplinary team, resident, and responsible party to discuss any concerns.</p> <p>* Monitor all smoking related behaviors.</p> <p>* Document all smoking related behavior.</p>			

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	<p>Upon violation of the smoking policy, the facility has the right to:</p> <ul style="list-style-type: none"> * Seize all smoking materials (cigarette lighter/matches, cigarettes on his/her person or suspicion of any materials designed for the purpose of smoking) and notify the administrator or designee. * Once the smoking materials have been secured, facility staff will search the resident's person and room to ensure no other smoking materials are present. * On the next business day following a violation of the smoking policy, the facility administrator or designee have the option to begin searching for alternate placement for the resident. Once placement is found, the resident will be issued a 30 day notice of Transfer/Discharge due to endangerment of themselves and other residents." <p>3. The Social Service section of the resident record contained two entries related to smoking. An entry dated 03-30-12 acknowledged the resident had the smoking assessment complete, and 04-09-12 which indicated the resident "becomes upset when wanting medications or when [resident] wants to smoke outside scheduled smoking times</p>			

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	<p>in smoking policy. Resident not easily re-directed."</p> <p>Further review of the resident record lacked specific social service intervention, contract or other options as outlined in the facility smoking policy related to the resident's non compliance.</p> <p>3.1-34(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, the facility failed to ensure physician orders were followed as well as resident plans of care for 1 of 11 sampled residents reviewed related to following the plan of care and physician's orders. [Resident "D"].</p> <p>Findings include:</p> <p>1. The record for Resident "D" was reviewed on 05-23-12 at 9:50 a.m. Diagnoses included but were not limited to confusion, falls, dementia, hypertension, hypothyroidism and impulse control disorder. These diagnoses remained current at the time of the record review.</p> <p>The nurses notes, dated 04-25-12 at 4:30 [a.m.] indicated the following: "Fall resident stood up from wheelchair and lost balance. Hit [R] [right] side of head. Hematoma with abrasion present. Area cleansed and left open to air. V/S [blood pressure] 120/69, [temperature] 97.7, [pulse] 86, and [respirations] 18."</p> <p>The next nurses note dated 04-25-12 at</p>	F0282	<p>1. Resident #D had ordered medications provided from the pharmacy and administered as ordered. 2. All residents with medication orders have the potential to be affected. All medication carts checked to ensure all ordered medications were present. All nurses in-serviced on the facility's policy on following physicians orders, medication administration and medication availability, (please see attachment A). 3. As a means to ensure ongoing compliance the DON or designee will complete medication cart audits to ensure all ordered medications are present weekly for 4 weeks, then every other week for 4 weeks, then monthly, (please see attachment E. Should a deficient practice be noted, immediate corrective action will be taken.4. As a quality measure the DON or designee will review any findings and subsequent corrective action(s) in response to the ongoing monitoring, in the facility's quarterly Quality Assurance meeting.</p>	06/18/2012			

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	<p>4:00 p.m., indicated "res. [resident] sent to [name of local area hospital] for eval [evaluation] and tx. [treatment] d/t [due to] fall in A.M. Res. lethargic, c/o [complains of] head pain, leaning to rt. [right] side, not willing to get out of bed. Neuro's [neurological checks] WNL [within normal limits] [blood pressure] 137/80, [temperature] 97.7, pulse] 78, and [respirations] 16. PERRLA <sic> [pupils equals and reactive to light], hand grips - equal. res. alert. [Family member] notified of fall et [and] send <sic> to [name of local area hospital]."</p> <p>The resident's plan of care indicated, "notify responsible party and MD [Medical Doctor] if a fall occurs." The nursing staff failed to immediately notify the resident's physician for possible intervention or the resident's responsible party of the resident's fall with injury.</p> <p>In addition, the resident's April 2012 Medication Administration Record indicated the resident had physician orders, dated 11-30-11, for Amiodarone Hcl [a medication for hypertension] 200 mg by mouth daily, Folic Acid [a supplement] ordered 11-30-11, 1 mg daily, Leucovorin Calcium, 5 mg every Monday, and Levothyroxine [a thyroid medication] 88 mcg [micrograms] daily.</p>			

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	<p>The April 2012 Medication Administration Record indicated the resident did not receive the following medications as ordered by the physician:</p> <p>"04-18-12 at 9:00 p.m. and again on 04-24-12 at 9:00 p.m. - Levoxthyroxine 88 mcg "Not available in drawer or overflow or EDK [Emergency Drug Kit] - ordered."</p> <p>"04-23-12 9:00 a.m. Amiodarone 200 mg not available in drawer or overflow - ordered."</p> <p>"04-23-12 9:00 a.m. Folic Acid 1 mg - not available in drawer or overflow - ordered."</p> <p>"04-23-12 9:00 a.m. Leucovorin Calcium 5 mg not available - ordered."</p> <p>This federal tag relates to Complaint IN00107672.</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 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure professional standards of care were followed, in that when a resident fell and sustained a head injury the nursing staff failed to complete the neurological assessments of a resident for 1 of 3 residents reviewed for falls and a head injury in a sample of 11. [Resident "D"].</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 05-23-12 at 9:50 a.m. Diagnoses included, but were not limited to, confusion, falls, dementia and impulse control disorder. These diagnoses remained current at the time of the record review.</p> <p>The resident Medication Administration Record indicated the resident had physician orders, dated 12-13-11 for Aspirin [a non-steroidal anti-inflammatory medication] 81 mg [milligrams] by mouth, one time - daily as</p>	F0309	<p>1. Resident #D had neurological checks completed and her care plan updated per facility policy. 2. All residents requiring neurological checks and care plan updates have the potential to be affected. All residents with neurological checks currently being completed will have documentation checked for accuracy. All nurses will be re-educated on the facility's policy on neurological check, care plan updates and documentation to include how to properly correct documentation errors, (please see attachment A). 3. As a means to ensure ongoing compliance the DON or designee will audit neurological forms, care plans, and documentation errors daily on regularly scheduled days for 1 month, then twice weekly for 1 month, then weekly for 1 month, then monthly to ensure accurate documentation is present, (please see attachment F). Should deficient practice be noted, immediate corrective action will be taken. 4. As a quality measure the DON or designee will review any findings and subsequent</p>	06/18/2012			

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	<p>well as Plavix [an anti-platelet medication] 75 mg one capsule daily ordered 02-28-12.</p> <p>The resident's plan of care indicated, "Notify responsible party and MD [Medical Doctor] if a fall occurs."</p> <p>The nurses notes, dated 04-25-12 at 4:30 [a.m.] indicated the following: "Fall resident stood up from wheelchair and lost balance. Hit [R] [right] side of head. Hematoma with abrasion present. Area cleansed and left open to air. V/S [blood pressure] 120/69, [temperature] 97.7, [pulse] 86, and [respirations] 18."</p> <p>The next nurses note, dated 04-25-12 at 4:00 p.m., indicated, "Res. [resident] sent to [name of local area hospital] for eval [evaluation] and tx. [treatment] d/t [due to] fall in A.M. Res. lethargic, c/o [complains of] head pain, leaning to rt. [right] side, not willing to get out of bed. Neuro's [neurological checks] WNL [within normal limits] [blood pressure] 137/80, [temperature] 97.7, pulse] 78, and [respirations] 16. PERRLA <sic> [pupils equals and reactive to light], hand grips - equal. res. alert. [Family member] notified of fall et [and] send <sic> to [name of local area hospital]."</p> <p>The neurological assessment as</p>		corrective action(s) in response to the ongoing monitoring, in the facility's quarterly Quality Assurance meeting.	

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	<p>documented at 4:00 p.m., prior to the resident being transported to the local area hospital were the neurological assessments taken at 1:30 p.m., from the assessment flowsheet.</p> <p>The facility Assistant Director of Nurses provided a policy on 05-24-12 at 2:00 p.m., which was titled "Neurological Checks Procedure," dated 09-05, and instructed the nursing staff to assess the resident initially, then once every 1/2 hour for the first hour, then every hour for the next 4 hours, then every two hours for the next 8 hours, then every 4 hours for the next 12 hours, then daily for the next 6 days.</p> <p>The licensed nurse initiated neurological checks per facility policy as the initial checks were completed, as well as at 5:00 a.m., 5:30 a.m., 6:30 a.m., 7:30 a.m., 8:30 a.m., 9:30 a.m., 11:30 a.m., and 1:30 p.m. However, review of the actual "Neurological Assessment Flowsheet" indicated the licensed nurse continued to document assessments for this resident at 3:30 p.m., 7:30 p.m. and 11:00 p.m. The flow sheet had the word "error" adjacent to the 3:30 p.m., 7:30 p.m. and 11:00 p.m. entries.</p> <p>During interview on 05-24-12 at 3:05 p.m., the Unit Manager, licensed nurse</p>			

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	<p>employee #6, indicated she "saw the flow sheet" when she arrived at work the following morning [04-26-12] and questioned the licensed nurse, employee #17. Licensed nurse, employee #17, explained to the Unit Manager that he confused Resident "D" with another resident and inaccurately documented the neurological checks for the other resident on Resident "D's" flow sheet. Once he realized the error he "lined through" the vital signs and then transcribed them onto the correct resident's flowsheet.</p> <p>During this interview the other resident's flow sheet was compared with Resident "D's" flow sheet. The form lacked corresponding vital signs or neurological assessments as license nurse employee #17 had indicated to his Supervisor. The Unit Manager indicated the documentation of the neurological checks/assessments did not correspond.</p> <p>The Unit manager indicated the licensed nurse could not have completed assessments on Resident "D," "because [resident] had been sent to the hospital."</p> <p>The licensed nurse failed to document a current assessment of the resident prior to transport to the local area hospital and failed to document as assessment, per facility policy, at 3:30 p.m.</p>						

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	<p>Review of the Encyclopedia and Dictionary of Medicine, Nursing and Allied Health - Second edition on 05-29-12 at 1:00 p.m., indicated the following related to the need for monitoring of a resident's condition after a fall which resulted in a head injury:</p> <p>"Continuous monitoring of the vital signs and assessment of the neurological status are essential to the care of the resident with a head injury. Any one of the following symptoms should be reported to the physician (1) changes in the blood pressure, pulse or respiratory rate, especially slowing of the pulse with a rising blood pressure, (2) extreme restlessness or excitability following a period of comparative calm. (3) deepening stupor of intensity, (5) vomiting, especially persistent, projectile vomiting (6) unequal size of pupils, (7) inability to move one or more extremity."</p> <p>This federal tag relates to Complaint IN00107672.</p> <p>3.1-37(a)</p>						

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure adequate supervision of a resident, in that when a resident was designated and assessed as a "smoker," the facility failed to ensure the resident was supervised with smoking activities and smoking paraphernalia for 1 of 2 residents identified as a smoker who needed supervision in a sample of 11. [Resident "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 05-23-12 at 10:25 a.m. Diagnoses included, but were not limited to, squamous cell carcinoma - cervical with metastasis, behavior issues, history of depression, anxiety, chronic obstructive pulmonary disease, and borderline personality disorder. These diagnoses remained current at the time of the record review.</p> <p>The "Mood and Behavior Communication Memo's" indicated the following infractions related to the facility smoking</p>	F0323	<p>1. Resident #C has been promptly re-educated on the facility's smoking policy each time non-compliance was noted. The physician is aware of resident #C's non-compliance. One should note resident #C is her own responsible party. There is a smoke detector in her room and her room was checked to ensure there were no smoking materials. A behavior contract has been completed between the facility and resident #C.</p> <p>2. The facility has identified all of the residents that smoke as well as the residents who have been non-compliant with the facility's smoking policy. All residents that choose to smoke have been educated on and signed the facility's smoking policy. A smoking assessment has been completed on all residents that smoke to ensure appropriate interventions are in place as to promote resident safety which are care planned as well. Smoke detectors have been placed in the rooms of residents who have been non-compliant, if not already in place. Staff will be re-educated on the facility's smoking policy including handling of smoking</p>	06/18/2012

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	<p>policy:</p> <p>"04-03-12 - (time not documented) cigarettes found and lighter on person. pt. [patient] [Resident "C"] education given on facility policy and stated understood supervisor 3 - 11 aware." This behavior memo was completed by licensed nurse, employee #16.</p> <p>"04-12-12 at 2:20 p.m. - Resident ["C"] was smoking with another resident that had not lit cigarette yet. Went out to tell them it was not smoking time. When I asked for the lighter and ciggerrets <sic> [resident] started raising voice. They both were willing to come back in but were not willing to give lighter or cigarettes <sic> to me." This behavior memo was completed by activity staff member, employee #14.</p> <p>"04-14-12 at 9:30 a.m. [Resident "C"] was wanting me [employee receptionist #13] to give a pack of cigarettes and was upset that I wouldn't. [Resident "C"] kept saying [resident] only had 2 to 3 months to live. I gave [Resident "C"] 2 cigarettes and I shouldn't have done that." This behavior memo was completed by the Receptionist, employee #13.</p> <p>"04-23-12 at 12:00 a.m. and 2:00 a.m. - Resident ["C"] outside smoking at</p>		<p>paraphernalia and behavior monitoring, (please see attachment A).</p> <p>3.As a measure to ensure ongoing compliance the SSD or designee will complete room checks daily on the residents who have exhibited non-compliant behaviors related to the smoking policy, (please see attachment D). Smoking assessments will be completed by Social Services at least quarterly and with any significant change in condition. The SSD or designee will review all behavior memos daily in the morning meeting to ensure appropriate interventions implemented promptly. The SSD or designee will complete follow up documentation to address each behavior exhibited. The unit managers will read nurses notes to ensure all items documented are addressed per facility policy daily on regularly scheduled days and initial upon review, (please see attachment C). Additionally the DON or designee will review the nurses notes daily on regularly scheduled days as a second check to ensure all issues are addressed appropriately. Should deficient practice be noted, immediate corrective action will be taken.</p> <p>4.As a measure of quality assurance the SSD or designee and DON or designee will review any findings and subsequent corrective action(s) in response to the ongoing monitoring, in the</p>				

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	<p>midnight with [name of another resident's family members]. Tried to convince me to smoke with them so [Resident "C"] could stay out. Said [Resident "C"] will be in when [resident] is done. At 2:00 a.m. [Resident "C"] attempted to go out again to smoke saying we don't know [Resident "C"] pain. I told [Resident "C"] was not to go out [Resident "C"] finally turned around and started to cry." This behavior memo was completed by CNA [Certified Nurses Aide], employee #15</p> <p>"05-17-12 Resident ["C"] was found outside courtyard by the chapel smoking, staff went and ask <sic> Resident ["C"] to come in because staff needed to supervise [Resident "C"] (8:15 p.m.) Resident ["C"] came in without incident then at 8:35 p.m. while staff was on lunch CNA [certified nurses aide] came to let me know that resident was in church parking lot smoking. Went to see had LOA [leave of absence] book been signed and it wasn't. Staff asked resident to come in and [Resident "C"] stated [Resident "C"] signed LOA book and remained outside... ." This communication was signed by licensed nurse, employee #16.</p> <p>The resident record contained an assessment, dated 03-30-12, in which the resident was identified as "alert and oriented" and recommendations for</p>		<p>facility's quarterly Quality Assurance meeting.</p>				

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	<p>"smoking with supervision (facility policy)." In addition the facility smoking policy, contained within the record, signed and dated 03-30-12, indicated the resident was made aware of the facility smoking policy.</p> <p>During interview on 05-24-12 at 3:05 p.m., the Unit Manager, licensed nurse employee #6 indicated the problems/concerns with the resident's non-compliance with the facility smoking policy continued. "Today [Resident "C"] was found with 6 cigarettes found hidden underneath the cushion on [resident] wheelchair."</p> <p>2. The facility policy, dated 12-19-11, indicated, "The policy of this facility that the safety of all residents, whether he/she smokes or not, will be ensured. This care center will be a smoke free building with the exception of the following areas: main lounge court yard [bold type].</p> <p>The facility smoking policy included the following steps for safe smoking:</p> <p>* Designated smoke times - 6:30 a.m., 10:00 a.m., 2:30 p.m., 7:00 p.m. and 10:30 p.m.</p> <p>* Staff will educate residents on the following, but not limited to: 4. Storage</p>			

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	<p>of smoking items, 5. Violation of facility smoking policy.</p> <p>* Smoking sessions will be supervised by a staff member only.</p> <p>* All smoking materials will be kept at the A-wing nurse's station. Smoking material will be distributed by a staff member.</p> <p>* Families/responsible parties will be instructed that all smoking materials must be brought to the nurse's station and will be distributed by staff.</p> <p>* Resident may not have cigarettes or lighters in their possession.</p> <p>The facility has the right to:</p> <p>* implement a behavioral contract, which will specify conduct and obligations of the resident.</p> <p>* Contact the ombudsman and schedule a formal meeting with the interdisciplinary team, resident, and responsible party to discuss any concerns.</p> <p>* Monitor all smoking related behaviors.</p> <p>* Document all smoking related behavior.</p>			

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	<p>Upon violation of the smoking policy, the facility has the right to:</p> <ul style="list-style-type: none"> * Seize all smoking materials (cigarette lighter/matches, cigarettes on his/her person or suspicion of any materials designed for the purpose of smoking) and notify the administrator or designee. * Once the smoking materials have been secured, facility staff will search the resident's person and room to ensure no other smoking materials are present. * On the next business day following a violation of the smoking policy, the facility administrator or designee have the option to begin searching for alternate placement for the resident. Once placement is found, the resident will be issued a 30 day notice of Transfer/Discharge due to endangerment of themselves and other residents." <p>4. Further review of the resident record lacked specific interventions, contract or other options as outlined in the facility smoking policy related to the resident's non compliance.</p> <p>5. During interview the Administrator indicated no steps had been taken to address the resident's non compliance</p>			

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	with the facility smoking policy. 3.1-45(a)(2)				

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F0493 SS=E	<p>483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN</p> <p>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>Based on interview, the facility failed to ensure facility staff as well as contracted covered individuals were aware of their role and obligations in reporting reasonable suspicion of a crime, in that the facility Administrator failed to provide inservice education to new hired staff as well as contracted covered individuals in regard to the Elder Justice Act for 1 of 1 policy reviewed. This deficient practice had the potential to affect 137 of 137 residents currently residing in the facility.</p> <p>Findings include:</p> <p>During interview on 05-23-12 at 3:15 p.m., the Administrator indicated the facility staff had received inservice education related to Abuse/Elder Justice Act.</p> <p>When further interviewed on 05-24-12 at 12:45 p.m., the Administrator indicated</p>	F0493	<p>1. Shift to shift education on the Elder Justice Act was implemented immediately. 2. Required postings for the Elder Justice Act are displayed in the front lobby area. Elder Justice Act Information binders are available at each nurses' station. All staff, including contracted staff, will have education on the Elder Justice Act provided, (please see attachment H). All employee files will be audited to ensure the education on the Elder Justice Act is present. 3. As a measure to ensure ongoing compliance the Elder Justice Act information has been added to the new orientation packet, the annual in-service calendar includes education on the Elder Justice Act annually, and the General Orientation check list has the Elder Justice Act education included. The Business Office Manager or designee will complete an audit weekly on all new hires to ensure the Elder Justice Act education has been completed, (please see attachment G). Should deficient</p>	06/18/2012	

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	<p>the facility had not complied with the regulation and that after the initial inservice education "last year," the inservice education related to the Elder Justice Act had not been added to the required annual inservice education nor for newly hired staff members. In addition, the Administrator indicated contracted staff had not received the education related to the Elder Justice Act. "[Name of former employee] was responsible for making sure everyone had the education. After he left I didn't follow up to make sure it had been done or added to the annual inservices or education for contracted covered staff members."</p> <p>During interview on 05-23-12 at 8:40 a.m., contracted staff member licensed nurse employee #1 indicated she was "unaware of the Elder Justice Act." "I have reported some concerns to the Administrator, but not all concerns".</p> <p>During interview on 05-23-12 at 8:55 a.m., housekeeper employee #4 indicated she had recently been hired at the facility. The housekeeper indicated she was aware of the facility abuse policy but unaware of the "Elder Justice Act." The housekeeper indicated, "I never heard of that - it's good to know."</p> <p>During interview on 05-24-12 at 12:45</p>		<p>practice be noted, immediate corrective action will be taken.4. As a quality measure the Business office Manager will review any findings and subsequent corrective action(s) in response to the ongoing monitoring, in the facility's quarterly Quality Assurance meeting.</p>	

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	<p>p.m., contracted licensed nurse employee #9 indicated the she received information on the Elder Justice Act "this morning and had not received the information prior to the inservice education."</p> <p>During interview on 05-24-12 at 1:00 p.m., contracted licensed nurse employee #10 indicated "They gave us a big packet of papers to read this morning and told us it was the Elder Justice Act. I'm not going to lie, I haven't had time to read the entire packet but did get through the first two pages."</p> <p>During interview on 05-24-12 at 3:45 p.m., both the Social Service Director and the Social Service Designee indicated they both received the information "this morning." Further interview with the Social Service Designee indicated she was not aware of the "specifics" related to the Elder Justice Act. The Social Service Director prompted the Social Service Designee, "that's the paper you signed this morning."</p> <p>This federal tag relates to Complaint IN00107672.</p> <p>3.1-13(a)</p>			

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