

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
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NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit resulted in an Extended Survey-Substantiated Substandard Quality of Care.</p> <p>Survey dates: June 15, 16 and 17, 2015</p> <p>Extended Survey Dates: June 18, 19, 20, 21, 22, 23 and 24, 2015.</p> <p>Facility number: 000545 Provider number: 15E594 AIM number: 100267350</p> <p>Census bed type: NF: 30 Total: 30</p> <p>Census payor type: Medicaid: 27 Other: 3 Total: 30</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1</p>	F 0000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under Federal and State law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0164 SS=G Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview and record review, the facility failed to maintain a resident 's privacy while providing a bed bath for 1 of 4 residents observed for personal care. Resident #36 was fully exposed, pulling at sheets to cover herself, pulling into the fetal</p>	F 0164	F164 The facility provides the resident the right to personal privacy and confidentiality of his or her clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care,	07/24/2015	

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	<p>position, and trying to cover her breasts during the care. This deficient practice affected 1 of 30 residents. (Resident #36)</p> <p>Findings include:</p> <p>1. During an observation of care on 06/17/2015 at 10:30 a.m. CNA #1 was observed to provide a bed bath to Resident #36. CNA #1 gathered the supplies for the bed bath and then began to remove all of Resident #36's clothing. CNA #1 began cleansing the resident. CNA #1 did not pull the privacy curtain around the resident. The resident's roommate was present in the room. During the bed bath, Resident #36 was observed to be lying fully unclothed on the bed and was observed to repeatedly attempting to cover her chest and move into the fetal position during the bed bath. Resident #36 would scream out, cry during the care and would yell, "...no, no, no...stop... stop..." while attempting to cover herself. CNA #1 continued to bathe the resident during this time. CNA #1 was observed to call the resident "honey" The resident was observed to say "...no man...no man ..." as she attempted to cover her breasts and cry. At 10:48 a.m., CNA #1 was observed to place a blanket over the resident.</p> <p>On 6/18/15 at 9:27 a.m., Resident #36 's</p>		<p>visits, and meetings of family and resident groups. Corrective action for residents affected: CNA #1 was suspended immediately from facility and Around the Clock (ATC) Agency was notified of the allegation. The guardian of Resident #36 was notified and informed of the alleged deficit practice. Resident #36 is not interviewable. The guardian requested to speak with surveyors because she was upset that the surveyors had a problem with how the bed bath was completed on Resident #36. She informed the ED that she knows the resident frequently verbalizes resistance to care and that the care rendered here is the best care the resident has received in a nursing facility. Other residents having the potential to be affected and corrective actions: All residents who require bathing per bed bath have the potential to be affected by this alleged deficient practice. The DON or designee will observe all scheduled bed baths until staff education is completed to ensure privacy/dignity is provided. Measures to ensure practice does not recur: Nursing staff and outside agency staff will be re-in serviced on resident rights, privacy / dignity, proper bathing of a resident. The DON or designee has completed education on bed baths utilizing the ISDH Nurse Aide Training Curriculum to ensure bathing practice is in</p>				

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	<p>record was reviewed. Diagnoses included, but were not limited to, anxiety, senile psychosis, dementia, and insomnia.</p> <p>On 6/17/15 at 10:38 a.m., CNA #1 indicated Resident #36 would need to say stop three times before she would stop providing care. CNA #1 indicated Resident #36 was a "...screamer..."</p> <p>On 06/17/15 at 10:53 a.m., CNA #1 indicated the facility policy was to close all doors and privacy curtains during care and she would have placed a towel over Resident #36 but she would have just kept moving it off.</p> <p>The Minimum Data Set (MDS) dated 05/16/15, indicated Resident #36 was severely cognitively impaired and was totally dependent on two staff for bathing.</p> <p>On 6/23/15, a current facility policy provided by the Administrator titled, "Resident Rights" dated 1997 indicated, "...The resident has a right to a dignified existence ...Privacy and Confidentiality.. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. i) Personal privacy includes accommodations, medical treatment ...personal care ...4) Quality of Life ...a) Dignity: A facility</p>		<p>compliance. Care plans and CNA Assignment sheets were updated to ensure current resident needs. Failure to comply with facility policy regarding privacy and dignity during personal care will result in disciplinary action up to and including termination of employment. This corrective action will be monitored by: A QA audit tool will be utilized 2 times per week x 4 weeks, then 1 time per week x 4 weeks, then once every 2 weeks x 4 months during observation of bed baths. Audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>		

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F 0222 SS=D Bldg. 00	<p>must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality ... "</p> <p>3.1-3(p)(4)</p> <p>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on interview and record review the facility failed to determine the presence of a specific medical symptom that would require the use of an antipsychotic medication used as a chemical restraint for 1 of 1 residents reviewed for chemical restraints. (Resident #26)</p> <p>Findings include: On 06/17/2015 at 3:55 p.m., the record review for Resident #26 was completed. Diagnoses including, but were not limited to, dementia (alcohol induced), auditory hallucinations and history of substance abuse.</p> <p>A MDS (Minimum Data Set) assessment</p>	F 0222	<p>F222 The facility provides the resident the right to be free from any chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.</p> <p>Corrective action for residents affected: Resident #26 was re-evaluated by the psychiatrist on 6/30/15. Psychopharmacological medications and mental status / behavior mood state were reviewed with no medication changes made. Other residents having the potential to be affected and corrective actions: All residents receiving</p>	07/24/2015	

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	<p>dated 4/04/15 indicated a BIMS (Brief Interview for Mental Status) of 10 indicating moderate cognitive impairment. The MDS also indicated that the resident was always continent.</p> <p>A physician order dated 4/27/2015 at 1:00 p.m., indicated to give Haldol Decanoate (an antipsychotic medication) 25 mg (milligrams) IM (Intramuscularly Injection) now for delusions.</p> <p>A review of Resident #26's Behavioral/Intervention Monthly Flow Record dated 4/01/2015 indicated Resident #26's behaviors to be pacing, refusing medications, and delusions. Interventions included reassure resident, ensure resident's safety, honor resident's wishes, reapproach (sic) later, and alternate caregivers. The Behavior/Intervention Monthly Flow Record indicated that Resident #26 exhibited pacing behaviors on 4/1, 4/2, 4/7, and 4/9; Refusal of medications on 4/13, 4/14, 4/20, 4/21, and 4/22; no delusional behaviors were documented for the month of April 2015.</p> <p>A review of Resident #26's clinical record indicated in a nursing note dated 4/21/15 at 11:47 p.m., resident refused medication. Interventions of 1:1, back rub, conversation, left alone and</p>		<p>psychopharmacological medications have the potential to be affected by this alleged deficient practice. The Consultant Pharmacist completed a medication regimen review on all current residents on 6/30/15 which included review of psychopharmacological medication orders and supportive diagnosis. The Behavior IDT has reviewed all applicable residents to ensure appropriate documentation is in place to support the medical necessity of the drug.</p> <p>Measures to ensure practice does not recur: Facility policy has been reviewed and updated as deemed necessary to ensure compliance with freedom from chemical restraint. Staff has been re-educated on facility policy and behavior documentation.</p> <p>This corrective action will be monitored by: Review of documented behaviors will continue 5 days per week during the morning meeting. SSD will audit and document psychopharmacological medication usage and compare to behavior documentation once per week x 6 months. Audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement,</p>		

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	<p>reapproached (sic), offered snack, redirected, reoriented were tried with outcome unchanged. A nurses note dated 4/24/15 at 11:28 a.m., indicated Resident #26 refused medications. Interventions included 1:1 with social worker, assessed for pain, conversation, given food, left alone and reapproached (sic), offered snack, redirected, reoriented, television/radio with outcome unchanged.</p> <p>A social services note dated 4/30/15 indicated the resident had not showered or changed his pants in about 3 weeks. The Director of Nursing was to contact Resident #26's guardian and the doctor to see what the options were as resident had an offensive odor and visibly soiled clothing.</p> <p>The Medication Administration Record (MAR) for April, 2014 indicated Resident #26 had received his scheduled Haldol Decanoate injection on 4/24/2015.</p> <p>A review of April shower sheets received from the Director of Nursing on 6/22/2015 at 8:15 a.m., dated 4/24/15 and 4/14/15 indicated the resident refused a shower on those dates. The record lacked documentation of Resident #26 either receiving or refusing showers on any additional dates in April.</p>		and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015		

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	<p>An interview with the Director of Nursing (DON) on 06/19/2015 at 2:58 p.m., indicated that Resident #26 had a very rough couple a weeks and the physician witnessed these behaviors on 4/27/2015. The DON indicated Resident #26 was pacing, refusing care, and incontinent which are Resident #26's normal behaviors. The DON indicated that many staff had tried to talk to Resident #26 into taking a shower and changing his cloths, Resident #26 refused. The DON indicated at this point, on 4/27/2015, Resident #26's condition was a sanitary issue to other residents. The DON indicated that the physician saw these behaviors and ordered the Haldol.</p> <p>An interview with the Medical Director on 06/22/2015 3:36 p.m., indicated he would have to look at the chart in regards to the incident on 4/27/15 but he generally does not resort to an IM injection unless the resident is being delusional and aggressive.</p> <p>A current facility policy provided by the Administrator on 06/23/15 at 3 p.m., titled, "Resident Rights" dated 1997, indicated, "...the resident has the right to be free from any physical or chemical restraints imposed for purpose of discipline or convenience and not</p>			

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F 0225 SS=F Bldg. 00	<p>required to treat the resident's medical symptoms...."</p> <p>3.1-3(w)</p> <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</p>			

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	<p>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, interview and record review the facility failed to ensure allegations of resident to resident abuse, physical, verbal and sexual abuse were thoroughly investigated, failed to ensure protection of other residents during the investigation and failed to report to the Indiana State Department of Health (ISDH) and law enforcement for 4 of 4 abuse allegation reviewed (Residents #4, #19, #32, and a confidential interview). This deficient practice had the potential to affect 30 of 30 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During a stage 1 confidential interview with a resident on 06/15/15 at 2:17 p.m., the resident indicated the Administrator, Social Services Director (SSD) and Activities Director (AD) had been verbally and physically abusive to her. The resident also indicated she had been sexually abused by a group of "...black men ..." who had abused her orally and anally. The resident indicated</p>	F 0225	<p>F225 The facility ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately, are investigated, and results of investigations are reported in accordance with state law. We respectfully request the allegations at 1, 2, and 4 be stricken from the Statement of Deficiencies through IDR based upon evidence submitted in Exhibit B. We believe the facility did investigate allegations of abuse, did protect other residents during the investigation, and did report alleged abuse upon full disclosure by survey team. Corrective action for residents affected: 1. Confidential resident: Upon notification by surveyor of alleged physical and verbal abuse per confidential resident, the ED immediately contacted the corporate CEO. The CEO instructed that the ED, SSD, and AD be confined to the basement area that does not house residents receiving certified services until she arrived to begin investigation. The CEO arrived on</p>	07/24/2015

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	<p>she had been too scared to notify staff of the abuse. The Administrator was notified of the anonymous allegations on 06/15/15 at 2:51 p.m.</p> <p>An Indiana State Department of Health (ISDH) Incident Report Form provided by the Administrator on 06/17/15 at 9:50 a.m., indicated "Initial Report: 06/15/15..Follow-up Report: 06/16/15...Resident Name: Unknown ...Summary of interview with person(s) reporting the incident ...: Survey team arrived 06/15/15 [sic] Survey team reported a resident wishing to stay anonymous stated the Administrator / [sic] the activities director and the social worker [sic] were all three physically and verbally abusive to them. I was then notified. I asked how I was to investigate abuse of an anonymous resident (via conference call). I asked surveyor who stated she needed to ask her supervisor. Surveyor returned to room and instructed me to interview random staff. I arrived to building at 9 am 6/16/15. I interviewed 5 residents and two staff. No allegations of abuse of any type reported by any resident. No witness of abuse by staff ...Conclusion: allegation of abuse</p>		<p>6/16/15 and conducted interviews with 5 residents and 2 staff regarding any instances of observed practices that could constitute physical or verbal abuse. All interviews were negative for indicators of abuse by staff to residents. As stated in the survey citation, the ED submitted the report of alleged abuse to the ISDH on 6/15/15 after notification per surveyor. The resident's allegation of sexual abuse was not reported on 6/15/15 along with the afore-mentioned abuse because the surveyor did not elaborate this concern per the confidential interview with the resident. Instead, she asked the ED whether the ED knew anything about "black men". The surveyor supervisor met with the ED on 6/17/15 and asked whether anything about sexual abuse regarding black men had been reported to ISDH. The ED asked what the supervisor was talking about. The supervisor stated that the surveyor team had informed her of an allegation of sexual abuse by the confidential resident. The ED informed the supervisor that was not correct. She further informed the supervisor she had requested a written list of concerns from the survey team on 6/16/15 because they had verbalized an extensive amount of concerns on the first day of the survey [6/15/15], and she wanted to be sure she had</p>	

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	<p>unsubstantiated based on interview w/ (with) 5 residents and 2 staff claiming no physical or verbal abuse " Incident report formed was signed by the CEO [Chief Executive Officer]. The sexual abuse allegation was not included as investigated on the Incident Report Form. An ISDH Incident Report Form provided by the Administrator on 06/19/15 at 3:16 p.m., indicated, "Initial Report: 06/17/2015. Follow-up Report: 06/19/2015...Resident Name ...Brief Description of Incident: On 06/15/2015 Surveyor interviewed [resident identified] and returned to the Executive Director stating that the resident had allegations against black men ...Immediate Action: When [resident identified] by surveyor on 06/17/15, Executive Director immediately interviewed [resident identified]. The question was asked, 'Has [sic] a male or any black men entered your room uninvited?' She replied, 'Yes but I didn't know them. There were seven of them.'...Resident indicated that 'You and the staff all know about it. I didn't know the state would tell you'...' " The confidential resident was not identified to</p>		<p>addressed all concerns. The survey team leader had responded that they were not allowed to provide a list in writing. The ED stated to the supervisor she wished to meet with the team to discuss the fact that she had not been provided any information about sexual abuse by black men toward a resident. She showed the survey team the note she made on her note pad while speaking with the surveyor on 6/15/15 that had the words "black men" written below the notes about the allegation of physical and verbal abuse. The surveyor supervisor informed the ED on 6/17/15 that the concerns could be provided in writing, and she proceeded to instruct the team to provide this. Upon receiving the additional information of the sexual abuse allegation per the confidential interview, the ED immediately reported to ISDH and initiated the investigation per facility policy. The survey citation validates that the team was provided a copy of the ISDH report dated 6/17/15. Local law enforcement was notified on 6/19/15 and was involved in the investigation. The follow-up report was submitted on 6/19/15 with no substantiation of the allegation. 2. Resident #4 – The survey citation states the ED was informed of an allegation regarding sexual abuse verbalized by this resident during surveyor interview on 6/15/15.</p>		

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	<p>the Administrator by the survey staff.</p> <p>On 6/17/15 at 12:45 p.m., the Administrator indicated the sexual abuse allegation had not been reported with the physical and verbal allegations. The Administrator indicated the words "black men" had been written on her desk calendar but nothing had been written after those words and she had not followed up.</p> <p>On 6/22/15 at 8:10 a.m., the Administrator provided A Resident Abuse Investigation Report Form which indicated " [Resident identified] ... Additional Comments: Surveyor was reporting abuse on 3 department heads for verbal and physical abuse and when ED (Executive Director) was taking notes used ink. During conversation ED had to laid [sic] down pen - in pencil beside ink notes on calendar ED wrote "black men." Surveyor did not elaborate. This allegation was reported to state after clarification between surveyor and ED regarding black men " The form indicated the police department was notified of allegation on 06/19/15 at 10:15 a.m.</p> <p>On 6/23/15 at 11:35 a.m., the</p>		<p>That is not a factual statement. The ED was asked by the team leader on 6/15/15 whether she was aware of any "sexual concerns" in the building. The ED responded she was not aware of any sexual concerns. The team leader ended the conversation by leaving the ED office. The ED was first informed that this was an allegation on 6/17/15 when the surveyor supervisor stated she (ED) was not following federal guidelines regarding abuse identification, investigation, and reporting. The supervisor was shown the ISDH reportable log maintained by the ED. The supervisor stated to the ED that she had been informed of an allegation of sexual abuse verbalized by Resident #4 on 6/15/15. The ED again met with the surveyor team and requested additional information regarding this new allegation per Resident #4. The team leader responded that she had informed the ED that this resident had expressed a concern regarding sexual abuse. The ED stated she would immediately begin an investigation now that she had clarification of the extremely vague question regarding "sexual concerns" as stated above. The survey citation validates that the team was provided a copy of the ISDH report dated 6/17/15. The ED interviewed Resident #4 on 6/17/15 regarding concerns related to sexual abuse. The</p>				

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	<p>Administrator indicated the police were not notified of the sexual abuse allegations until 06/19/15. The Administrator indicated the allegation had been reported to ISDH but then "...it clicked..." and realized she needed to call the police department.</p> <p>2. On 6/15/15 at 10:36 a.m., during a stage 1 interview with Resident #4, the resident indicated other residents in the facility have "...requested sex from him..." The resident indicated, "...he told staff and they didn't do anything" Resident #4 indicated he had not been sexually abused. The Administrator was notified of the allegation on 06/15/15 at 2:15 p.m.</p> <p>On 06/17/15 at 12:45 p.m., the Administrator indicated the sexual abuse allegation had not been reported to ISDH or investigated.</p> <p>On 6/18/15 the Administrator provided an ISDH Incident Report Form indicated, "Brief Description of Incident ...Surveyor interview resident who indicated that he had been sexually abused. He indicated that other residents kept approaching him and wanting sex from him...."</p> <p>On 6/22/15 at 8:10 a.m., a Resident</p>		<p>resident laughed and stated that this happened a long time (over ten years) ago, and the resident who had requested sex from him has since passed away. The ED also contacted the resident's POA who stated "Is he bringing this up again? It isn't true. He doesn't think straight". A follow up report was submitted to ISDH on 6/19/15 indicating the allegation of current sexual abuse was unsubstantiated. 3. Resident #19 – The DON was aware of the resident to resident physical contact that occurred while the residents were preparing to leave for an activity outing on 6/12/15. Resident #19 was immediately checked for injury, and no physical evidence of injury was found. The physician who oversees the medical care for the male resident perpetrator was contacted and gave an order for the resident to be transferred for psychiatric evaluation and treatment. The DON then secured the safety of Resident #19 by implementing the order to send the perpetrator out. She also prepared a written report of the unusual occurrence as instructed by the ED who was not available to complete the report on 6/12/15. The DON informed the ED on 6/15/15 that she was so busy arranging for the transfer of the perpetrator that she failed to submit the report on 6/12/15. The ED completed a Teachable Moment with the DON regarding</p>				

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	<p>Abuse Investigation Report Form was provided by the Administrator indicated, "...Summary of interview with person(s) reporting the incident ...Surveyor came into Executive Director's office, surveyor asked the ED a question, 'are you aware of any sexual concerns in the facility,' [sic] I replied no. Surveyor left my office...Summary of investigator 's findings:...no surveyor did not say concern/complaint ...now that you are saying it is a concern I will immediately investigate... "</p> <p>3. On 6/15/15 at 10:24 a.m., during a stage 1 interview, Resident #19 indicated another resident struck her on the left shoulder. This incident had occurred on the previous Friday. Resident #19 also indicated the same resident had walked in while she had been in the shower room while she had been showering. Resident #19 indicated she reported both incidents to facility staff.</p> <p>On 6/17/15 at 9:50 a.m., the Administrator provided an ISDH Incident Report Form indicated, "Initial Report: 06/15/2015. Follow-up Report: 06/15/2015...Brief Description of Incident: While awaiting their turns to get</p>		<p>the importance of timely reporting and initiating an investigation to ensure resident safety and freedom from abuse. 4. Resident #32 - RN #2 was immediately suspended pending investigation. The ED interviewed Resident #32; the resident denied any mistreatment or abusive actions by staff. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. A Teachable Moment regarding professional conduct was completed with RN #2 upon reinstatement of job duties. All current residents, known family members or legal representatives of these residents, and all current employees and agency staff were interviewed regarding any observed staff actions or practices that could constitute abuse or mistreatment toward a resident. All interviews were negative for abuse or mistreatment. All allegations involving abuse or mistreatment since the survey have been reported timely, thoroughly investigated, and acted upon as deemed appropriate in accordance with facility policy, federal regulations, and the ISDH Reportable Incidents Policy and Procedure last revised 01/15/13.</p> <p>Measures to ensure practice does not recur: Facility policy regarding abuse identification, investigation, and ISDH / other</p>				

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	<p>on activities bus, residents...arguing about who would sit in front seat... Activities Director then heard [Resident #19] exclaim, 'He hit me.' She turned around and immediately escorted all residents back into the building...residents escorted to their respective rooms...she then reported immediately to DON, Administrator and Social Services Director....[resident name] sent to out to [hospital name]... [Resident #19] glad resident is gone..."</p> <p>On 6/22/15 at 8:10 a.m., the Administrator provided a Resident Abuse Investigative Report Form indicated, "....Date Incident Occurred: 06/12/15. Time: 11:45 AM. Date Incident Reported: 06/15/15...Summary of interview with person(s) reporting the incident...:Activity Director came to ED office, Social Service & DON were present in office. Activity Director stated I [sic] just brought residents back in I heard [Resident #19] say 'He hit me. '....Summary of interview with resident.....viewing notes from DON dated 06/12/15 at 12:05 p.m. - [sic] resident also told her verbal threats made...."</p>		<p>state agency reporting was reviewed and updated as deemed necessary The ED and DON were in-serviced on facility policy by the corporate compliance officer (CCO). CCO or designee will complete reviews at least once per week of all incidents, accidents, and unusual occurrences to ensure ISDH reporting requirements are met, and investigations are completed per facility policy. The CEO will be notified of any non-compliance in this area and will determine appropriate action(s). A Guardian Angel Program has been implemented which requires department heads to visit a group of residents twice weekly to review care received and inspect the resident's environment. Any indicators of potential abuse or mistreatment identified through the program will be immediately reported to the ED and acted upon. The ED will request all participants in the morning meetings to report any observed staff to resident or resident to resident behavior(s) that could constitute abuse daily Monday or Friday. The ED will immediately act upon any concerns reported. All current facility employees and agency staff replacement have been in-serviced on abuse prohibition and reporting in accordance facility policy. This corrective action will be monitored by: The corporate nurse consultant will review all</p>	

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	<p>On 06/22/15 at 11:54 a.m., the Administrator indicated the facility policy was to call resident to resident abuse in to ISDH as a reportable. The Administrator indicated she had been out of the building when the incident occurred on 06/12/15 and the DON should have reported the incident to ISDH. The Administrator indicated the incident was not reported to ISDH or investigated until 06/15/15.</p> <p>4. During a breakfast observation on 06/15/15 at 8:15 a.m., RN #1 was observed to approach Resident #32 in the dining room. RN #1 was observed to have a small cup in her hand and another small object in her other hand. RN #1 was observed to state to Resident #32 in a harsh tone, "I'm not dealing with this right now ..." while waving her hand in the air. RN #1 was then observed to walk away from the resident. The Administrator was informed of the event after it occurred.</p> <p>On 6/17/15 at 12:45 p.m., the Administrator indicated the incident had not been reported to ISDH or investigated. The Administrator indicated the allegation had not investigated</p>		<p>minutes from morning meetings and reports of incidents or unusual occurrences during routine visits to ensure any occurrence that meets the ISDH reportable requirements has been appropriately reported and investigated. The CCO will complete weekly reviews as stated above. Written results of the Guardian Angel visits will be reviewed by the IDT once weekly on-going. Immediate corrective actions will be implemented if indicators of abuse or mistreatment are identified. Guardian Angel visit results will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>				

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	<p>because the surveyor had not identified the resident to the administrator.</p> <p>An ISDH Incident Report Form provided by the Administrator on 06/18/15 indicated, "...Incident Date 06/15/2015...Resident identified on 06/17/15 ...Brief Description of Incident: ...surveyor was in facility conducting annual survey and was in dining room when she stated that she witnessed [RN #1] attempting to administer medications to ...a resident in a high backed chair ... [RN #1] raised her voice and threw her hands in the air stating, 'I'm not dealing with this right now' and walked away.</p> <p>The Executive Director asked who RN #1 was talking toSurveyor indicated that she would get back to Executive Director as to the identity of the resident ...</p> <p>"Immediate Action: [RN #1 returned to workfollowing a separate incident ...after being provided the identity of the resident involved in above-stated incident"</p> <p>On 6/22/15 at 8:10 a.m., a Resident Abuse Investigation Report Form provided by the Administrator indicated , "Statement - surveyor conducting observation in dining room when [RN</p>			

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	<p>#1] was attempting to administer meds (medications), employee raised voice, threw hand in air 'I'm not dealing with this right now - walked away. [sic] ...only witness was surveyor to ED knowledge...unsubstantiated ..."</p> <p>On 6/24/15 at 2:00 p.m., the Administrator indicated the investigation focused on the residents in high backed wheelchairs because the surveyor indicated Resident #32 observed was in a high back wheelchair. The Administrator indicated she did not attempt to interview or identify other residents who fit the description of the resident because of the high backed wheelchair.</p> <p>On 6/17/15 at 2:45 p.m., a current facility policy provided by the Administrator titled "Abuse Policy and Procedure (Including Elder Justice Act)" dated 09/25/12, indicated, "Policy: It is the mission of this facility to provide its residents with a safe and pleasant environment in which to live. The facility will endeavor to prevent, report the mistreatment, neglect or abuse of all residents and the misappropriation of property ...Procedure: Abuse is the willful infliction of injury, unreasonable</p>			

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	<p>confinement, intimidation or punishment with resulting physical harm or pain or mental anguish ...This presumes that instances of abuse of all residents ...cause physical harm, or pain or mental anguish ...Immediately report abuse/suspected abuse to the Charge Nurse. The Charge Nurse is to immediately report abuse to the Administrator, who the Abuse Coordinator, and/or the DON if the Administrator is unreachable ...All staff are required to report (phone, fax, electronic mail, mail) reasonable suspicion of a crime against a resident to the local law enforcement within: a. 2 hours - for Serious Bodily Injury if the events that cause the reasonable suspicion result in serous [sic] bodily injury to a resident, the staff member shall report the suspicion not later than 2 hours after forming the suspicion. b. 24 hours - for All Others [sic] suspicions [sic] of crime against a resident if the events that cause the reasonable suspicion do not result in serous [sic] bodily injury to a resident, the staff shall report the suspicion not later than 24 hours after forming the suspicion ...7. The Administrative/designee will be</p>			

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F 0226 SS=F Bldg. 00	<p>responsible to complete a REPORTABLE UNUSUAL OCCURRENCE [sic] form within 24 hours of occurrence via voicemail and send to the ISDH. 8. The Administrator/designee will investigate the situation and report the results of the investigation to ISDH within five working days of the incident ..."</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview and record review the facility failed to follow and impletment their abuse policy to ensure allegations of resident to resident abuse, physical, verbal and sexual abuse were were thoroughly investigated, failed to ensure protection of other residents during the investigation and failed to report to the Indiana State Department of Health (ISDH) and law enforcement for 4 of 4 abuse allegations. (Residents #4, #19, #32, and a confidential interview)</p>	F 0226	<p>F226 The facility developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>We respectfully request the allegations at 1, 2, and 4 be stricken from the Statement of Deficiencies through IDR based upon evidence submitted in Exhibit C. We believe the facility abuse policy</p>	07/24/2015
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	<p>This deficient practice had the potential to affect 30 of 30 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During a stage 1 confidential interview with a resident on 06/15/15 at 2:17 p.m., the resident indicated the Administrator, Social Services Director (SSD) and Activities Director (AD) had been verbally and physically abusive to her. The resident also indicated she had been sexually abused by a group of " ...black men ..." who had abused her orally and anally. The resident indicated she had been too scared to notify staff of the abuse. The Administrator was notified of the anonymous allegations on 06/15/15 at 2:51 p.m.</p> <p>An Indiana State Department of Health (ISDH) Incident Report Form provided by the Administrator on 06/17/15 at 9:50 a.m., indicated "Initial Report: 06/15/15..Follow-up Report: 06/16/15...Resident Name: Unknown ...Summary of interview with person(s) reporting the incident ...: Survey team arrived 06/15/15 [sic] Survey team reported a resident wishing to stay anonymous stated the Administrator /</p>		<p>was followed after full disclosure by the survey team. Corrective action for residents affected:</p> <p>1. Confidential resident: Upon notification by surveyor of alleged physical and verbal abuse per confidential resident, the ED immediately contacted the corporate CEO. The CEO instructed that the ED, SSD, and AD be confined to the basement area that does not house residents receiving certified services until she arrived to begin investigation. The CEO arrived on 6/16/15 and conducted interviews with 5 residents and 2 staff regarding any instances of observed practices that could constitute physical or verbal abuse. All interviews were negative for indicators of abuse by staff to residents. As stated in the survey citation, the ED submitted the report of alleged abuse to the ISDH on 6/15/15 after notification per surveyor. The resident's allegation of sexual abuse was not reported on 6/15/15 along with the afore-mentioned abuse because the surveyor did not elaborate this concern per the confidential interview with the resident. Instead, she asked the ED whether the ED knew anything about "black men". The surveyor supervisor met with the ED on 6/17/15 and asked whether anything about sexual abuse regarding black men had been</p>				

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	[sic] the activities director and the social worker [sic] were all three physically and verbally abusive to them. I was then notified. I asked how I was to investigate abuse of an anonymous resident (via conference call). I asked surveyor who stated she needed to ask her supervisor. Surveyor returned to room and instructed me to interview random staff. I arrived to building at 9 am 6/16/15. I interviewed 5 residents and two staff. No allegations of abuse of any type reported by any resident. No witness of abuse by staff ...Conclusion: allegation of abuse unsubstantiated based on interview w/ (with) 5 residents and 2 staff claiming no physical or verbal abuse " Incident report formed was signed by the CEO [Chief Executive Officer]. The sexual abuse allegation was not included as investigated on the Incident Report Form. An ISDH Incident Report Form provided by the Administrator on 06/19/15 at 3:16 p.m., indicated, "Initial Report: 06/17/2015. Follow-up Report: 06/19/2015...Resident Name ...Brief Description of Incident: On 06/15/2015 Surveyor interviewed [resident identified] and returned to the Executive		reported to ISDH. The ED asked what the supervisor was talking about. The supervisor stated that the surveyor team had informed her of an allegation of sexual abuse by the confidential resident. The ED informed the supervisor she had requested a written list of concerns from the survey team on 6/16/15 because they had verbalized an extensive amount of concerns on the first day, and she wanted to be sure she had addressed all concerns. The survey team leader had responded that they were not allowed to provide a list in writing. The ED stated the supervisor she wished to meet with the team to discuss the fact that she had not been provided any information about sexual abuse by black men toward a resident. She showed the survey team the note she made on her note pad while speaking with the surveyor on 6/15/15 that had the words "black men" written below the notes about the allegation of physical and verbal abuse. The surveyor supervisor informed the ED on 6/17/15 that the concerns could be provided in writing, and she proceeded to instruct the team to provide this. Upon receiving the additional information of the sexual abuse allegation per the confidential interview, the ED immediately reported to ISDH and initiated the investigation per facility policy. The survey citation validates that the team was				

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	<p>Director stating that the resident had allegations against black men ...Immediate Action: When [resident identified] by surveyor on 06/17/15, Executive Director immediately interviewed [resident identified]. The question was asked, 'Has [sic] a male or any black men entered your room uninvited?' She replied, 'Yes but I didn't know them. There were seven of them.'...Resident indicated that 'You and the staff all know about it. I didn't know the state would tell you'...' The confidential resident was not identified to the Administrator by the survey staff. On 6/17/15 at 12:45 p.m., the Administrator indicated the sexual abuse allegation had not been reported with the physical and verbal allegations. The Administrator indicated the words "black men" had been written on her desk calendar but nothing had been written after those words and she had not followed up. On 6/22/15 at 8:10 a.m., the Administrator provided A Resident Abuse Investigation Report Form which indicated " [Resident identified] ... Additional Comments: Surveyor was</p>		<p>provided a copy of the ISDH report dated 6/17/15. Local law enforcement was notified on 6/19/15 and involved in the investigation. The follow-up report was submitted on 6/19/15 with no substantiation of the allegation. 2. Resident #4 – The survey citation states the ED was informed of an allegation regarding sexual abuse verbalized by this resident during surveyor interview on 6/15/15. That is not a factual statement. The ED was asked by the team leader on 6/15/15 whether she was aware of any "sexual concerns" in the building. The ED responded she was not aware of any sexual concerns. The team leader ended the conversation by leaving the ED office. The ED was first informed that this was an allegation on 6/17/15 when the surveyor supervisor stated she (ED) was not following federal guidelines regarding abuse identification, investigation, and reporting. The supervisor was shown the ISDH reportable log maintained by the ED. The supervisor stated to the ED that she had been informed of an allegation of sexual abuse verbalized by Resident #4 on 6/15/15. The ED again met with the surveyor team and requested additional information regarding this new allegation per Resident #4. The team leader responded that she had informed the ED that this resident had expressed a</p>				

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	<p>reporting abuse on 3 department heads for verbal and physical abuse and when ED (Executive Director) was taking notes used ink. During conversation ED had to laid [sic] down pen - in pencil beside ink notes on calendar ED wrote "black men." Surveyor did not elaborate. This allegation was reported to state after clarification between surveyor and ED regarding black men " The form indicated the police department was notified of allegation on 06/19/15 at 10:15 a.m.</p> <p>On 6/23/15 at 11:35 a.m., the Administrator indicated the police were not notified of the sexual abuse allegations until 06/19/15. The Administrator indicated the allegation had been reported to ISDH but then "...it clicked..." and realized she needed to call the police department.</p> <p>2. On 6/15/15 at 10:36 a.m., during a stage 1 interview with Resident #4, the resident indicated other residents in the facility have "...requested sex from him..." The resident indicated, "...he told staff and they didn't do anything" Resident #4 indicated he had not been sexually abused. The Administrator was</p>		<p>concern regarding sexual abuse. The ED stated she would immediately begin an investigation now that she had clarification of the extremely vague question regarding "sexual concerns" as stated above. The survey citation validates that the team was provided a copy of the ISDH report dated 6/17/15. The ED interviewed Resident #4 on 6/17/15 regarding concerns related to sexual abuse. The resident laughed and stated that this happened a long time (over ten years) ago, and the resident who had requested sex from him has since passed away. The ED also contacted the resident's POA who stated "Is he bringing this up again? It isn't true. He doesn't think straight". A follow up report was submitted to ISDH on 6/19/15 indicating the allegation of current sexual abuse was unsubstantiated.</p> <p>3. Resident #19 – The DON was aware of the resident to resident physical contact that occurred while the residents were preparing to leave for an activity outing on 6/12/15. Resident #19 was immediately checked for injury, and no physical evidence of injury was found. The physician who oversees the medical care for the male resident perpetrator was contacted and gave an order for the resident to be transferred for psychiatric evaluation and treatment. The DON then secured the safety of Resident</p>				

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	<p>notified of the allegation on 06/15/15 at 2:15 p.m.</p> <p>On 06/17/15 at 12:45 p.m., the Administrator indicated the sexual abuse allegation had not been reported to ISDH or investigated.</p> <p>On 6/18/15 the Administrator provided an ISDH Incident Report Form indicated, "Brief Description of Incident ...Surveyor interview resident who indicated that he had been sexually abused. He indicated that other residents kept approaching him and wanting sex from him...."</p> <p>On 6/22/15 at 8:10 a.m., a Resident Abuse Investigation Report Form was provided by the Administrator indicated, "...Summary of interview with person(s) reporting the incident ...Surveyor came into Executive Director's office, surveyor asked the ED a question, 'are you aware of any sexual concerns in the facility,' [sic] I replied no. Surveyor left my office...Summary of investigator 's findings:...no surveyor did not say concern/complaint ...now that you are saying it is a concern I will immediately investigate... ."</p> <p>3. On 6/15/15 at 10:24 a.m., during a stage 1 interview, Resident #19 indicated</p>		<p>#19 by implementing the order to send the perpetrator out. She also prepared a written report of the unusual occurrence as instructed by the ED who was not available to complete the report on 6/12/15. The DON informed the ED on 6/15/15 that she was so busy arranging for the transfer of the perpetrator that she failed to submit the report on 6/12/15. The ED completed a Teachable Moment with the DON regarding the importance of timely reporting and initiating an investigation to ensure resident safety and freedom from abuse.</p> <p>4. Resident #32 - RN #2 was immediately suspended pending investigation. The ED interviewed Resident #32; the resident denied any mistreatment or abusive actions by staff.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. A Teachable Moment regarding professional conduct was completed with RN #2 upon reinstatement of job duties. All current residents, known family members or legal representatives of these residents, and all current employees and agency staff were interviewed regarding any observed staff actions or practices that could constitute abuse or mistreatment toward a resident. All interviews were</p>				

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	<p>another resident struck her on the left shoulder. This incident had occurred on the previous Friday. Resident #19 also indicated the same resident had walked in while she had been in the shower room while she had been showering. Resident #19 indicated she reported both incidents to facility staff.</p> <p>On 6/17/15 at 9:50 a.m., the Administrator provided an ISDH Incident Report Form indicated, "Initial Report: 06/15/2015. Follow-up Report: 06/15/2015...Brief Description of Incident: While awaiting their turns to get on activities bus, residents...arguing about who would sit in front seat... Activities Director then heard [Resident #19] exclaim, 'He hit me.' She turned around and immediately escorted all residents back into the building...residents escorted to their respective rooms...she then reported immediately to DON, Administrator and Social Services Director....[resident name] sent to out to [hospital name]... [Resident #19] glad resident is gone..."</p> <p>On 6/22/15 at 8:10 a.m., the Administrator provided a Resident Abuse Investigative Report Form indicated,</p>		<p>negative for abuse or mistreatment. All allegations involving abuse or mistreatment since the survey have been reported timely, thoroughly investigated, and acted upon as deemed appropriate in accordance with facility policy, federal regulations, and the ISDH Reportable Incidents Policy and Procedure last revised 01/15/13.</p> <p>Measures to ensure practice does not recur: Facility policy regarding abuse identification, investigation, and ISDH / other state agency reporting was reviewed and updated as deemed necessary The ED and DON were in-serviced on facility policy by the corporate compliance officer (CCO). CCO or designee will complete reviews at least once per week of all incidents, accidents, and unusual occurrences to ensure ISDH reporting requirements are met, and investigations are completed per facility policy. The CEO will be notified of any non-compliance in this area and will determine appropriate action(s). A Guardian Angel Program has been implemented which requires department heads to visit a group of residents twice weekly to review care received and inspect the resident's environment. Any indicators of potential abuse or mistreatment identified through the program will be immediately reported to the ED and acted</p>				

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	<p>"....Date Incident Occurred: 06/12/15. Time: 11:45 AM. Date Incident Reported: 06/15/15...Summary of interview with person(s) reporting the incident...:Activity Director came to ED office, Social Service & DON were present in office. Activity Director stated I [sic] just brought residents back in I heard [Resident #19] say 'He hit me. '....Summary of interview with resident...:...viewing notes from DON dated 06/12/15 at 12:05 p.m. - [sic] resident also told her verbal threats made...." On 06/22/15 at 11:54 a.m., the Administrator indicated the facility policy was to call resident to resident abuse in to ISDH as a reportable. The Administrator indicated she had been out of the building when the incident occurred on 06/12/15 and the DON should have reported the incident to ISDH. The Administrator indicated the incident was not reported to ISDH or investigated until 06/15/15. 4. During a breakfast observation on 06/15/15 at 8:15 a.m., RN #1 was observed to approach Resident #32 in the dining room. RN #1 was observed to</p>		<p>upon. The ED will request all participants in the morning meetings to report any observed staff to resident or resident to resident behavior(s) that could constitute abuse daily Monday or Friday. The ED will immediately act upon any concerns reported. All current facility employees and agency staff replacement have been in-serviced on abuse prohibition and reporting in accordance facility policy. This corrective action will be monitored by: The corporate nurse consultant will review all minutes from morning meetings and reports of incidents or unusual occurrences during routine visits to ensure any occurrence that meets the ISDH reportable requirements has been appropriately reported and investigated. The CCO will complete weekly reviews as stated above. Written results of the Guardian Angel visits will be reviewed by the IDT once weekly on-going. Immediate corrective actions will be implemented if indicators of abuse or mistreatment are identified. Guardian Angel visit results will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon</p>				

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	<p>have a small cup in her hand and another small object in her other hand. RN #1 was observed to state to Resident #32 in a harsh tone, "I'm not dealing with this right now ..." while waving her hand in the air. RN #1 was then observed to walk away from the resident. The Administrator was informed of the event after it occurred.</p> <p>On 6/17/15 at 12:45 p.m., the Administrator indicated the incident had not been reported to ISDH or investigated. The Administrator indicated the allegation had not investigated because the surveyor had not identified the resident to the administrator.</p> <p>An ISDH Incident Report Form provided by the Administrator on 06/18/15 indicated, "...Incident Date 06/15/2015...Resident identified on 06/17/15 ...Brief Description of Incident: ...surveyor was in facility conducting annual survey and was in dining room when she stated that she witnessed [RN #1] attempting to administer medications to ...a resident in a high backed chair ... [RN #1] raised her voice and threw her hands in the air stating, 'I'm not dealing with this right now' and walked away.</p>		<p>compliance rates. Completion Date July 24, 2015</p>	

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	<p>The Executive Director asked who RN #1 was talking toSurveyor indicated that she would get back to Executive Director as to the identity of the resident ...</p> <p>"Immediate Action: [RN #1 returned to workfollowing a separate incident ...after being provided the identity of the resident involved in above-stated incident"</p> <p>On 6/22/15 at 8:10 a.m., a Resident Abuse Investigation Report Form provided by the Administrator indicated ,</p> <p>"Statement - surveyor conducting observation in dining room when [RN #1] was attempting to administer meds (medications), employee raised voice, threw hand in air 'I'm not dealing with this right now - walked away. [sic] ...only witness was surveyor to ED knowledge...unsubstantiated ..."</p> <p>On 6/24/15 at 2:00 p.m., the Administrator indicated the investigation focused on the residents in high backed wheelchairs because the surveyor indicated Resident #32 observed was in a high back wheelchair. The Administrator indicated she did not attempt to interview or identify other residents who fit the description of the resident because of the</p>			

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	<p>high backed wheelchair.</p> <p>On 6/17/15 at 2:45 p.m., a current facility policy provided by the Administrator titled "Abuse Policy and Procedure (Including Elder Justice Act)" dated 09/25/12, indicated, "Policy: It is the mission of this facility to provide its residents with a safe and pleasant environment in which to live. The facility will endeavor to prevent, report the mistreatment, neglect or abuse of all residents and the misappropriation of property ...Procedure: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish ...This presumes that instances of abuse of all residents ...cause physical harm, or pain or mental anguish ...Immediately report abuse/suspected abuse to the Charge Nurse. The Charge Nurse is to immediately report abuse to the Administrator, who the Abuse Coordinator, and/or the DON if the Administrator is unreachable ...All staff are required to report (phone, fax, electronic mail, mail) reasonable suspicion of a crime against a resident to the local law enforcement within: a. 2</p>			

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F 0241 SS=D Bldg. 00	<p>hours - for Serious Bodily Injury if the events that cause the reasonable suspicion result in serous [sic] bodily injury to a resident, the staff member shall report the suspicion not later than 2 hours after forming the suspicion. b. 24 hours - for All Others [sic] suspicions [sic] of crime against a resident if the events that cause the reasonable suspicion do not result in serous [sic] bodily injury to a resident, the staff shall report the suspicion not later than 24 hours after forming the suspicion ...7. The Administrative/designee will be responsible to complete a REPORTABLE UNUSUAL OCCURRENCE [sic] form within 24 hours of occurrence via voicemail and send to the ISDH. 8. The Administrator/designee will investigate the situation and report the results of the investigation to ISDH within five working days of the incident ..."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that</p>			

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	<p>maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to maintain a resident's dignity during dining observation when the resident was removed from eating his meal for medication administration in a public area and while providing a bed bath to a dependent resident. This deficient practice affected 2 of 30 residents reviewed for dignity. (Residents #12 and #36)</p> <p>Findings include:</p> <ol style="list-style-type: none"> During a dining observation on 6/15/2015 at 8:53 a.m., RN #2 (Registered Nurse) was observed to walk up to Resident #12's wheelchair and pull resident away from the dining table. Resident #12 was eating his breakfast of scrambled eggs when RN #2 wheeled him out of the dining area. Resident #12 began to yell "Wait a minute! Where are we going?" RN#2 was heard saying "Shhhhh" to resident #12 as she wheeled him past several residents seated in the dining room eating breakfast. RN#2 was observed to wheel resident out the open double doors of the dining room parking him in front of the medication cart. At 8:58 a.m., RN #2 was observed to give 	F 0241	<p>F241</p> <p>The facility provides care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Corrective action for residents affected:</p> <ol style="list-style-type: none"> Resident #12 – RN #2 was suspended immediately pending investigation. The resident's family / legal representative was notified of the alleged deficient practice. The ED interviewed Resident #12 regarding staff treatment during the meal observed by the surveyor. Resident #12 had no recall of the meal or of any adverse staff actions. Resident #36 - CNA #1 was suspended immediately from facility and Around the Clock (ATC) Agency was notified of the allegation. The guardian of Resident #36 was notified and informed of the alleged deficit practice. Resident #36 is not interviewable. The guardian requested to speak with surveyors because she was upset that the surveyors had a problem with how the bed bath was completed on Resident #36. She informed the ED that she knows the resident frequently verbalizes resistance to care and that, in her opinion, the care rendered here is 	07/24/2015

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	<p>resident #12 an injection in his right upper arm. RN #2 then walked out of site before returning to the medication cart and Resident #12. RN #2 was observed handing Resident #12 a medication cup and a cup of water. Resident #12 was observed taking his medication. RN#2 stated "Give me a minute" and began to document in a chart sitting on the medication cart. At 9:03 a.m., RN #2 was observed returning resident #12 to his table, resident #12 proceed to eat his breakfast.</p> <p>During an interview with Resident #12 at 8:59 a.m., on 6/15/15, he indicated he did not know how breakfast was because he had not had an chance to finish it.</p> <p>During an interview with LPN #6 on 6/19/15 at 10:52 a.m., she indicated if the resident was eating she would wait until the resident was done eating to administer medications.</p> <p>Resident #12's record was reviewed on 06/19/15 at 11:07 a.m. Diagnosis included, but were not limited to CVA (Cerebral Vascular Accident), Hemiplegia (paralysis of half of the body), COPD (Chronic Obstructive Pulmonary Disease), and DM (Diabetes Mellitus). Minimum Data Set (MDS) assessment, dated 04/26/15, indicated</p>		<p>the best care the resident has received in a nursing facility. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. RN #2 was provided with education and a written counseling warning regarding the resident's right to be treated with dignity, and the need to provide privacy during administration of an injection. The DON or designee will observe scheduled bed baths until staff education is completed to ensure privacy/dignity is provided. A social service consultant completed interviews with five interviewable residents regarding concerns with how medications are administered. All interviews were negative for concerns. Measures to ensure practice does not recur: Nursing staff and outside agency staff will be re-in serviced on resident rights, privacy / dignity, proper bathing of a resident. The DON or designee has completed education on bed baths utilizing the ISDH Nurse Aide Training Curriculum to ensure bathing practice is in compliance. Care plans and CNA Assignment sheets were updated to ensure current resident needs. Failure to comply with facility policy regarding privacy and dignity</p>				

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	<p>Resident #12 was moderately cognitively impaired, and unable to self administer medications.</p> <p>A review of current facility policy provided by the Administrator on 06/23/15 titled, " Resident Rights " dated 1997 indicated, " ...(4) the resident has the right to refuse treatment..."...A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respects in full recognition of his or her individuality...."</p> <p>"...The resident has the right to (3) make choices about aspects of his or her life in the facility that are significant to the resident...."</p> <p>2. During an observation of care on 06/17/2015 at 10:30 a.m. CNA #1 was observed to provide a bed bath to Resident #36. CNA #1 gathered the supplies for the bed bath and then began to remove all of Resident #36's clothing. CNA #1 began cleansing the resident. CNA #1 did not pull the privacy curtain around the resident. The resident's roommate was present in the room. During the bed bath, Resident #36 was observed to be lying fully unclothed on the bed and was observed to repeatedly attempting to cover her chest and move into the fetal position during the bed bath. CNA #1 continued to bathe the</p>		<p>during personal care will result in disciplinary action up to and including termination of employment.</p> <p>This corrective action will be monitored by: A QA audit tool will be utilized 2 times per week x 4 weeks, then 1 time per week x 4 weeks, then once every 2 weeks x 4 months during observation of bed baths. Audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>				

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	<p>resident during this time. CNA #1 was observed to hold Resident #36's arm when resident attempted to cover her breast and was observed to call the resident "honey." At 10:48 a.m., CNA #1 was observed to place a blanket over the resident.</p> <p>On 6/18/15 at 9:27 a.m., Resident #36 's record was reviewed. Diagnoses included, but were not limited to, anxiety, senile psychosis, dementia, and insomnia.</p> <p>The Minimum Data Set (MDS) assessment dated 05/16/15, indicated Resident #36 was severely cognitively impaired and was totally dependent on two staff for bathing.</p> <p>On 6/17/15 at 10:38 a.m., CNA #1 indicated Resident #36 would need to say stop three times before she would stop providing care. CNA #1 indicated Resident #36 was a "...screamer... ."</p> <p>On 06/17/15 at 10:53 a.m., CNA #1 indicated the facility policy was to close all doors and privacy curtains during care and she would have placed a towel over Resident #36 but she would have kept moving it off.</p> <p>3.1-3(t)</p>			

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F 0247 SS=D Bldg. 00	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview the facility failed to provide notice to a resident prior to assigning a new roommate for 2 of 2 residents residents reviewed for roommate change. (Residents # 27 and #28)</p> <p>Findings include:</p> <p>During a stage 1 interview on 6/15/15 at 2:14 p.m., Resident #27 indicated he did not receive notice prior to Resident #28 being assigned to his room.</p> <p>On 6/17/15 at 10:15 a.m., the SSD (Social Service Director) and DON (Director of Nursing) indicated that a paper notice of change of roommate was not utilized for the change in roommate for resident #27. The SSD indicated that she had spoken to both Resident #27 and Resident #28 about the room change prior to the actual change and a note should be in the computer. SSD looked in computer system for the note and could not find one.</p>	F 0247	<p>F247</p> <p>The facility ensures the resident's right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Corrective action for residents affected: Resident #27 informed the SSD he wanted to move to Room #17 where Resident #28 resides. Resident #28 did not move. Since Resident #27 initiated the request for a room move, this does not constitute an involuntary intrafacility transfer, which per ISDH comprehensive care rules, requires a written notice. The SSD informed the surveyor that she had spoken with Resident #28 prior to the room move, and he agreed to the new roommate. The SSD had not entered the supportive documentation of this in the electronic record prior to the room move, and was not able to correct this.</p> <p>Other residents having the potential to be affected and corrective actions: All residents who have a change in room or roommate have the potential to be affected by this alleged deficient practice. Any resident who has had a change in</p>	07/24/2015	

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F 0309 SS=D Bldg. 00	<p>On 6/17/15 at 10:21 a.m., the SSD and DON indicated that a change in roommate can be triggered by a variety of things including circumstances or requests by residents. The interdisciplinary team would then discuss the change with the resident or guardian about the change and a note would be made in the SSD charting.</p> <p>On 6/17/15 at 10:43 a.m., the residents' records had no documentation of a notice of room change for either Resident #27 or Resident #28.</p> <p>On 6/18/15 at 3:04 p.m., the SSD provided an undated document titled, "A Room to Room Transfer Policy" which indicated "...2, Unless medically necessary or for the safety and well-being of the residents(s), a resident will be provided with an advance notice of the room transfer. Such notice will include the reason(s) why the move is recommended...."</p> <p>3.1-3(v)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p>		<p>room or roommate since the survey has been provided the applicable notice.</p> <p>Measures to ensure practice does not recur: Facility policy regarding a change in room or roommate has been reviewed and updated as deemed necessary. The SSD, ED, and DON have received education on facility policy.</p> <p>This corrective action will be monitored by: A QA audit tool will be utilized once per month by the CCO / designee to document review of all room and/or roommate changes and appropriate notices. Audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>				

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	<p>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 interview and record review, the facility failed to collaborate the care of a resident between the facility and hospice services for 1 of 1 resident being reviewed for hospice services. (Resident #34)</p> <p>Findings include:</p> <p>Resident #34's record was reviewed on 6/17/15 at 12:50 p.m. Diagnoses included, but were not limited to, decubitus ulcers, chronic pain, severe malnutrition, contractures on upper/lower extremities, anxiety disorder, chronic dysphagia, tracheostomy, and quadriplegia.</p> <p>A handwritten note in the front of Resident #34's chart indicated the Hospice HHA (Home Health Aide) would visit to provide personal care for him on: "Wednesdays-around lunch time (before)" "Fridays-after lunch around shift change-probably between 1-3 p.m."</p> <p>A document which indicated Start of Care "Hospice/LTC (Long Term Care)</p>	F 0309	<p>F309</p> <p>The facility provides to each resident all 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>Corrective action for residents affected: Resident #34 was provided bathing services per the hospice agency aide until the resident voluntarily discontinued hospice services effective 7/10/15. In addition to the agency services, the facility CNA provided bed baths / shower at the resident's request. The CNA Assignment Sheet and care plan have been updated to clearly reflect the services the facility is providing.</p> <p>Other residents having the potential to be affected and corrective actions: All residents receiving hospice services have the potential to be affected by this alleged deficient practice. There are currently two additional residents receiving hospice care. A meeting has been held with hospice agencies currently providing services to discuss care coordination and to ensure that each applicable</p>	07/24/2015

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	<p>Communication Tool" dated 2/16/15, indicated the hospice diagnosis was sepsis. The Hospice nurse visits were to be on Tuesdays and Thursdays with a start date of 2/22/15, and an end date of 3/1/15, and the Hospice Aide visits were to be on Mondays, Wednesdays and Fridays. There were no further visit dates listed for the Hospice Nurse or Aide. The tool indicated the Wound care schedule would start on 2/16/15, and the resident would have had visits on Tuesdays and Thursdays for wound care to a sacral wound daily, left hip every 3 days, the right hip and right scapula did not have any time frames for dressing change dates. The tool did not indicate when the facility would be responsible for changing the wound dressings or who would be responsible for measuring the wounds. The wounds listed on the communication tool were currently healed except the sacral wound.</p> <p>The resident had a Care Plan dated 3/2/15, which addressed the problem the resident had the potential for end of life (Hospice) related to terminal diagnosis. Approaches included, "3/2/15--Nurses--Administer medications as ordered, Frequent skin checks, assess and treat pain as needed/requested per orders, obtain vitals as needed/ordered, report concerns to physician and hospice.</p>		<p>resident receives planned services in accordance with the comprehensive assessment. The facility care plans and hospice plans of care for both current residents have been reviewed and updated to ensure they identify who will be responsible for providing planned services.</p> <p>Measures to ensure practice does not recur: All future residents who request and qualify for hospice services will have care coordinated through a meeting between the facility and the hospice provider of the resident's choice. The meeting will be scheduled within two (2) weeks after the hospice order is received. A facility policy addressing this new process has been developed and implemented.</p> <p>This corrective action will be monitored by: The corporate nurse consultant will review all residents with current hospice orders during routine visits to ensure care coordination. Findings will be discussed during exit conferences with the ED, DON, and/or SSD. Non-compliance will be reported to the corporate CEO and immediate corrective action implemented. Compliance reports will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance</p>				

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	<p>3/2/15--Nurse Aide--Reposition for comfort, Report pain indicators, Assist with ADL's as needed/requested, Lotion with cares, offer fluids with care... 3/2/15--All Staff--report concerns to nurses."</p> <p>The following resident Hospice documentation information was faxed to the facility by the hospice company on 6/22/15 at 2:28 p.m.</p> <p>The Hospice Aide Care Plan Report dated start of episode 5/17/15 and end of episode 7/15/15, indicated the effective date of the current Aide Care Plan was 2/28/15. These Care Plan Category/Services and Frequencies were on the Care Plan for the resident: Vital Signs: Weight-Monthly by the 5th of the month.</p> <p>ADL (Activity of Daily Living) services: Turn and position in bed, bathing, hair care, skin care, routine catheter care, perineal care, oral care/Dentures-every visit. Shampoo and nail care-weekly. Shaving-daily as resident desires.</p> <p>IADL (Independent Activity of Daily Living) Services: Empty trash, empty urinary drainage bag and tidy resident area-every visit</p>		<p>improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>		

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	<p>Change bed linens-weekly</p> <p>Intake/output: Output-urine-every visit Date of last BM-every visit</p> <p>Other Services: Report behaviors/LOC (Level of consciousness) issues to RN/CM (Case Manager), report skin issues to RN/CM, report bowel/bladder changes to RN/CM-every visit.</p> <p>A Physician Verbal Order dated 6/12/15 at 8:28 a.m., indicated the following orders: Service Changes: Effective Date of Calendar Frequency: 6/7/15 Calendar Frequency: HHA (Home Health Aide) 1 visit a week for 6 weeks. SN (Skilled Nursing) effective 6/14/15 1 visit a week for 5 weeks.</p> <p>The hospice sign in sheet in the front of the Hospice binder for visits for this resident indicated the hospice HHA signed the sheet for her last visit as of 5/27/15, and indicated her plan of next visit was to be 2 times per week. The Case Manager signed the sign in sheet for her last visit on 6/19/15, and did not indicate when her plan of next visit was</p>			
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	<p>to be.</p> <p>A "Hospice Certification and Plan of Care" document indicated: Orders of discipline and Treatments: "Hospice Nurse to Evaluate and Admit Patient and Develop Plan of Care to be Signed by Physician." "Hospice Nurse to Monitor Pain Level using Pain Scale each visit and Report changes in Pain Level to Physician." "Hospice Nurse Observation and Assessment of Cardiac/Circulatory system each visit." "Hospice Nurse Observation and Assessment of Sensory/Neurological Status." "Hospice Nurse Observation and Assessment of Nutrition and Hydration Status." "Hospice Nurse Observation and Assessment of Respiratory Status." "Hospice Nurse to Observe and Assess Genitourinary Pattern." "SN for O/A [open/area] of Integumentary Status for Early Identification of Complications." "Skilled Nurse to Provide Instructions Related to Decubitus Ulcer Care." "Skilled Nurse to Provide Instructions Related to Wounds." "Skilled Nurse to Provide Instructions/Reinforcement regarding care of the bowel incontinent patient."</p>			

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	<p>"Home Health Aide to assist with ADL'S and personal care needs."</p> <p>"Home Health Aide Services for assistance with Personal care and ADL's secondary to functional limitations, which prevent self-care. There is no willing or able caregiver to provide for hygiene needs."</p> <p>"Licensed Professional to report vital signs falling outside the following established parameters."</p> <p>There were no assessments found under the assessment tab in the Hospice binder for Resident #34. There was no recent ADL care information found in the Hospice binder documented for the resident.</p> <p>The current notes and Care Plan from the Hospice company was provided from the Administrator on 6/23/15 at 10:00 a.m. The Care Plan indicated some of the care provided to the resident by the Hospice company, but it did not indicate what care the facility was providing for the resident. The Care Plan from the facility did not indicate all the care they were providing for the resident and what care Hospice was responsible to provide for Resident #34.</p> <p>During an interview on 6/19/15 at 4:15 p.m., the DON (Director of Nursing)</p>			

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	<p>indicated the facility did not document the resident's showers because Hospice came into the facility and gave the resident his shower and they should be documenting the showers they were giving the resident in their hospice book.</p> <p>During an interview on 6/22/15 at 12:10 p.m., the DON indicated she did not know where the current hospice notes or hospice care plan for the resident was, but the resident's Hospice nurse could be reached at the Hospice Agency to get that information from her.</p> <p>During an interview on 6/22/15 at 12:20 p.m., the Administrator indicated she would contact the Hospice company and get the current hospice notes and Care Plan information.</p> <p>During an interview on 6/23/15 12:10 p.m., the Administrator indicated she talked to the Hospice company and she indicated the Hospice company had faxed over the current resident nurse and HHA visit notes and Care Plans. She was unable to indicate, by looking at the the Hospice Care Plan in the Hospice binder and the facility Care Plan what the Hospice and the facility responsibilities were for the resident. She indicated there was supposed to be a Care Plan for the Hospice company and the facility</p>			

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F 0312 SS=D Bldg. 00	<p>individually, which spelled out what kind of care each one of the companies were providing for the resident collaboratively, so both companies knew what kind of care was being provided for the resident.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to provide oral care for 2 of 2 residents reviewed for Activities of Daily Living. (Residents # 11 and #34)</p> <p>Findings include:</p> <p>1. On 6/17/15 at 9:21 a.m., the record review for Resident #11 was completed. Diagnoses included, but were not limited to dementia and high blood pressure.</p> <p>On 6/15/15 at 1:56 p.m., the resident's mouth contained pink debris between her teeth.</p> <p>On 6/16/15 at 2:22 p.m., during</p>	F 0312	<p>F312 Residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Corrective action for residents affected: 1. Resident #11 is receiving oral care daily. CNA Assignment Sheet has been updated to clearly reflect this need. The DON spoke the family member of Resident #11 who verified she spoke with a surveyor; however, she stated that she did not inform them that the facility was not providing oral care. The resident is receiving routine dental care per a private dentist's</p>	07/24/2015	

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	<p>interview, the family member indicated they had been taking the resident to the dentist every 3 months as they felt this was best since the facility was not providing oral care.</p> <p>On 6/17/15 9:36 a.m., the resident was observed to have white debris on the bottom teeth.</p> <p>On 6/17/15 at 3:30 p.m., the resident was observed sitting in the hallway with a white debris observed between her bottom teeth and an odor to her breath.</p> <p>On 6/18/15 at 2:34 p.m., the resident was observed with white debris in her bottom teeth on the right side.</p> <p>The shower schedule indicated on Tuesday and Friday in the evenings are the day that Resident #11 is scheduled to receive showers. The shower sheets dated for 6/2/15, 6/5/15, 6/9/15 and 6/16/15, had no indication of refusal of oral care and the box marked oral care completed was not checked.</p> <p>On on 6/19/15 at 10:08 a.m., the Director of Nursing indicated the oral care would be on the shower sheets. She indicated the box would be checked if the oral care had been done, and if the box was empty that would mean it had not been done.</p>		<p>recommendation.</p> <p>2. Resident #34 is being offered oral care daily; care is rendered if resident agrees. CNA Assignment Sheet has been updated to clearly reflect this need. The resident chose to discontinue hospice services effective 7/10/15.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents who require assistance with oral care have the potential to be affected by this alleged deficient practice. Assistance with oral care is offered to applicable residents daily by the assigned CNA. Documentation reflects whether the assistance was accepted or refused. CNA Assignment Sheets and care plans have been updated as needed.</p> <p>Measures to ensure practice does not recur:</p> <p>Nursing staff has been re-educated on the importance of providing assistance with oral care for residents who are unable to complete this task independently. Licensed nurses will be responsible for monitoring the oral hygiene of residents during each tour of duty. If poor oral hygiene is observed, the licensed nurse will immediately request the assigned CNA to offer assistance with oral care. If a resident repeatedly refuses oral care, the CNA will inform his/her licensed nurse supervisor. The</p>		

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F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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		nurse will document in the nursing notes and on the 24-hour report. The DON will be responsible for reviewing 24-hour reports daily Monday through Friday, and for bringing these reports to the morning meeting for further review and discussion. This corrective action will be monitored by: A QA audit tool will be utilized 2 times per week x 4 weeks, then 1 time per week x 4 weeks, then once every 2 weeks x 4 months by the DON / designee to ensure oral care provision. Audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015	

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	<p>developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure assessments of pressure ulcers were accurately completed with correct staging and appropriate infection control measures were followed to prevent possible infection was completed for 3 of 4 residents being reviewed for pressure ulcers. (Residents #34, #37, and #10)</p> <p>Findings include:</p> <p>1. Resident #34's record was reviewed on 6/17/15 at 12:50 p.m. Diagnoses included, but were not limited to, decubitus ulcers, chronic pain, severe malnutrition, contractures on upper/lower extremities, and quadriplegia.</p> <p>The resident's physician orders include, but were not limited to, the following orders:</p> <p>6/8/15--Clarification Gentamycin ointment (antibiotic ointment) swab into tunneling area on coccyx (bottom of the back bone) Pack tunneling area with 1/2' Iodoform gauze and cover with dry dressing twice daily and as needed for soilage.</p> <p>The Physician Progress Note dated 6/12/15, indicated the resident had no</p>	F 0314	<p>F314</p> <p>The facility ensures 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 residents with pressure sores will receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</p> <p>Corrective action for residents affected:</p> <p>1. Resident #34 – The pressure ulcer has been assessed and accurately staged. Documentation is available in the clinical record. The MDS and care plan have been updated.</p> <p>2. Resident #6 – The 2567 has an incorrect resident identifier listed at #2. The correct resident identifier is Resident #10 who has a right heel wound RN #4 received a Teachable Moment regarding proper cleansing and decontamination of scissors before and after use during wound care / dressing changes. The pressure ulcer has been assessed and accurately staged. Documentation is available in the clinical record. The MDS and care plan have been updated.</p> <p>3. Resident #37 - The pressure ulcer has been assessed and accurately staged. Documentation is available in the clinical record. The MDS and care</p>	07/24/2015			

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	<p>complaints, wounds were healing. The note indicated on 5/18/15, Hospice called the physician office and requested an order for a wound culture related to green foul smelling drainage, to discontinue the Santyl to the wound treatment and replace with Silvadene. The wound report indicated on 5/19/15, the coccyx wound Culture and Sensitivity had a light growth Gram Negative Rods (type of bacteria) with the Identity and Sensitivity to follow. Gram stain (type of test for bacteria) showed no white blood cells and no epithelial cells. There were a few gram negative road on 5/20/15. The note indicated on 5/21/15, the facility called the physician and indicated the resident had a fever of 99.5, with the small wound having a 2 cm tunnel and "nasty" yellow drainage. The facility indicated the wounds have gotten progressively worse and a new order was given to clean with soap and water, apply Gentamycin ointment to wound bed and tunnel, Pack area with Iodaform (iodine antiseptic) gauze twice a day, Cover with Normal and Dry Dressing.</p> <p>5/21/15--Nurses note indicated coccyx pressure ulcer Stage II. (Partial thickness loss of dermis presenting as a shallow open ulcer with a pink ulcer bed without slough) Present on Admission. 90% granulation. Red healthy normal tissue.</p>		<p>plan have been updated. Other residents having the potential to be affected and corrective actions: All residents with current pressure ulcers have the potential to be affected by this alleged deficient practice. All current residents with pressure ulcers have had the wounds assessed and accurately staged. Infection control practices during wound care / dressing changes have been observed and are applied in accordance with facility policy. Measures to ensure practice does not recur: Facility policy regarding pressure ulcer assessment and wound care / dressing changes have been reviewed and updated as deemed necessary. Licensed staff has been in-serviced on wound staging and assessment, as well as on infection control practices during wound care / dressing changes. The DON / designee will be responsible for observing licensed nurses performing wound care dressing changes including cleaning of equipment needed to ensure proper technique is used. This corrective action will be monitored by: A QA audit tool will be utilized 1 time per week x 8 weeks, then once every 2 weeks x 4 months by the DON / designee to observe wound care and ensure accurate documentation. Audit results will be presented during the monthly</p>				

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	<p>Improving becoming smaller. Measured 4.1 cm x 4.3 cm. Tunneling approximately 2.0 cm at 11 O'Clock. Purulent (discharge of pus) drainage noted on old dressing.</p> <p>5/27/15--Wound note indicated the coccyx pressure ulcer was a Stage II. Measured 4.0 cm x 3.0 cm x 1.5 cm. There was tunneling at the 12 O'clock position, but there was no measurements to indicate how much tunneling was present. The periwound indicated the surrounding tissue was white and moist. There was no wound bed description. The exudate color was tan with a thin consistency and a small amount. No nurses signature for completion of the note.</p> <p>6/3/15--Wound note indicated the coccyx pressure ulcer was a Stage II. Measured 4.1 cm x 3.0 cm x 2.0 cm. The note did not indicate if there was any tunneling or undermining. There was no exudate, wound bed or periwound description noted on the form. No nurses signature for completion of the note.</p> <p>6/10/15--Wound note indicated the coccyx pressure ulcer was a Stage II. Measured 4.0 cm x 2.5 cm x 3.0 cm. The note indicated tunneling was present at the 12 O'Clock position at a depth of 3.0</p>		<p>QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>				

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	<p>cm. There was a scant amount of a serous yellow exudate. There was no wound bed or periwound description on the note. No nurses signature for completion of the note.</p> <p>6/17/15--Wound note indicated the coccyx pressure ulcer was not Staged. Measured 4.0 cm x 3.0 cm. The depth of the wound was not decipherable due to the measurement was marked on the line, then the measurement had been scribbled out, so the measurement could not be read. The note indicated tunneling was present at a depth of 2.5 cm. There was yellow exudate without an odor. The wound bed and periwound was not described on this note. No nurses signature for completion of the note.</p> <p>The May and June 2015 wound notes indicated the wound was a stage II or was not staged at all. The wounds were inaccurately staged as defined by the American Medical Directors Association. A Stage III ulcer was a full thickness loss. Subcutaneous fact may be visible but not bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue lost. May include undermining or tunneling.</p> <p>The Administrator indicated LPN #21, the former MDS Coordinator was doing</p>			

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	<p>the wound measurements from 4/27/15 to 6/5/15, when she left without notice and the Administrator had been unable to locate her wound documentation on the resident's wounds. She indicated LPN #21 documented the wound measurements in the MDS (Minimum Data Set) assessments and she would get that information.</p> <p>On 6/23/15 at 2:22 p.m., Resident #34's coccyx pressure wound was observed to be seen with undermining from the 10-2 O'Clock position and there was yellow slough from 2 to the 6 O'Clock position. The rest of the wound bed was a pinkish/white color. During the wound care observation with LPN # 6, she indicated the resident's wound was a Stage II and he had slough and she pointed to the lower portion of his wound on the right side of his wound (at the lower part from the 2 to 6 o'clock) and she indicated he had tunneling and she pointed at the 12 0'clock position. She cleaned the wound with 4 x 4 gauze and NS (Normal Saline) in a circular motion, then she applied Gentamycin into the area of tunneling with two different cotton applicators from the 10 to the 2 o'clock area of the skin in the tunneled area. The cotton applicators were in an opened bag, then she cleansed her scissors with NS and a gauze, and laid</p>			

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	<p>them on the bed on the gauze she cleansed them with. She removed her gloves and sanitized her hands and got an alcohol wipe. She donned clean gloves. She pulled the iodoform gauze out with her hands then cut it with her scissors that had been laying on the residents bed, then put the part she did not use back in the bottle and took the gauze and packed the gauze into the undermining area with a cotton applicator that was in an opened package. Without removing her gloves, she used a Kleenex and removed sputum from his mouth</p> <p>During an interview on 6/23/15 at 2:53 p.m., LPN #6 indicated she should have removed her gloves and sanitized her hands between cleansing the wound and applying the Gentamycin ointment. She indicated the cotton applicators did not come in individual packages, so they had to use the applicators, which are in the packages with multiple applicators, which were already opened.</p> <p>During an interview on 6/23/15 at 3:00 p.m., the DON indicated the resident's coccyx wound was a Stage II.</p> <p>During an interview on 6/24/15 at 10:46 a.m., the DON indicated she the facility did not have a specific wound nurse. She indicated she could not identify who had</p>			

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	<p>completed the wound assessments since they were not signed.</p> <p>On 6/24/15 at 9:30 a.m., the Director of Nursing (DON) was requested to provide a Pressure wound policy and procedure. At the end of the Exit Conference on 6/24/15 at 7:15 p.m., there was no further information provided on the pressure policy and procedure.</p> <p>2. On 6/17/15 9:21 a.m., the record review for Resident # 6 was completed. Diagnoses included, but were not limited to, dementia, schizophrenia, left fracture of hip, peripheral vascular disease and depression.</p> <p>The physician's orders dated 6/9/15 indicated wound care to be dry dressing with gauze to the heel.</p> <p>On 6/23/15 at 11:09 a.m., RN #4 had her dressing change supplies, including scissors, prepared for the resident lying on top of the medication cart surface. RN #4 indicated the CNA's cleaned the residents heel in the shower. The residents heel was observed as open to air. The heel wound area was yellow on the perimeter of the wound and dark pink on the inside. RN # 4 indicated she thought the wound was between a Stage 1 and Stage 2. She indicated there was no order for cleaning of the area, just to</p>			

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	<p>put a pad on it and wrap with kerlix. She completed the treatment and cut the gauze and pad with the scissors that had been laying on the treatment cart. She did not clean the scissors before or after there were used and placed back on top of the treatment cart.</p> <p>3. On 06/24/2015 at 8:35 a.m., the record review for resident #37 was completed. Diagnoses included, but were not limited to, dementia, CVA (Cerebral Vascular Accident), and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>A significant change MDS completed 5/03/15 indicated Resident #37 had an unstageable wound to the right heel measuring 03.3 cm (centimeter) by 01.8 cm.</p> <p>The nurses note for Resident #37 indicated: 3/17/2015 at 6:00 p.m., indicated a black spot on the bottom of Resident #37's right heel.</p> <p>4/26/15 at 10:53 p.m., indicated Resident #37 had a stage IV pressure ulcer to right heel. The physician and guardian were notified at 10:55 p.m.</p> <p>4/28/15 at 2:14 p.m., indicated the resident had an unstageable area on the right heel that was dark and had calloused over. The measurements were</p>			

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	<p>3.3 cm x 1.8 centimeters.</p> <p>A physician progress note dated 4/24/15 indicated Resident #37's skin to be within normal limits.</p> <p>A physician order dated 4/28/15 indicated to soak right heel in warm soapy water for 15 minutes twice daily for 7 days.</p> <p>On 6/23/15 at 11:15 a.m., the Director of Nursing provided a document titled, Pressure/Stasis/Arterial/Diabetic Ulcer Assessment indicated Resident #37's wound to be a stage II on 5/15/15, 5/20/15, 5/27/15, 6/04/15 and on 6/11/2015.</p> <p>On 06/24/2015 at 11:29 a.m., Resident #37's wound was observed with LPN #3 (Licensed Practical Nurse). The wound was on the right heel of Resident # 37. Resident #37 was observed sitting in her wheel chair with soft boot on right foot. LPN #3 removed the current dressing. The dressing was observed to have a scant (small) amount of yellow drainage. The wound was observed to be black eschar (dead tissue). LPN #3 measured the wound as 2 cm. in length by 2 cm. in width.</p> <p>The residents wound was inaccurately staged as a stage II ulcer. The American</p>			

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F 0318 SS=G Bldg. 00	<p>Medical Directors Association defines an Unstageable Ulcer as "...full thickness loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown, and/or eschar (tan, brown, black) in the ulcer bed... Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore stage, cannot be determined...."</p> <p>3.1-40(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to ensure therapy interventions were in place to prevent contractures and worsening of contractures for 1 of 1 resident reviewed for range of motion. (Resident #34) Resident # 34 after admission, acquired upper arm, and finger contractures and the facility failed to initiate the recommended therapy and splinting.</p> <p>Findings include:</p>	F 0318	<p>F318 Based on the comprehensive assessment, the facility ensures that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Corrective action for residents affected: Resident #34 voluntarily discontinued hospice services effective 7/10/15. An order for Occupational Therapy has been</p>	07/24/2015

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	<p>During an interview on 6/15/15 at 11:53 a.m., LPN #6 indicated the Resident # 34 had bilateral upper arms, finger and wrist contractures and his right leg had limited ROM (range of motion). She indicated at that time, the resident was currently on Hospice, but was revoking Hospice at the end of the month to start therapy.</p> <p>Resident #34's record was reviewed on 6/17/15 at 12:50 p.m. Diagnoses included, but were not limited to, decubitus ulcers, chronic pain, severe malnutrition, contractures on upper/lower extremities, anxiety disorder, affective personality disorder, chronic dysphagia, tracheostomy, quadriplegia, and bipolar.</p> <p>On 6/17/15 at 12:34 p.m., the resident was observed lying in his bed with his left leg straight out, his right leg bent up and his bilateral wrists, fingers and arms had contractures. He indicated at that time, he did not have any therapy exercises being performed on his bilateral hands, arms or legs and he did not have splints that he wore.</p> <p>There were no physician orders found in his record for physical or occupational therapy.</p> <p>A "Resident Data Collection" form</p>		<p>requested from the resident's attending physician. The resident stated he desires to receive therapy services.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents with contractures or who are at risk for developing contractures have the potential to be affected by this alleged deficient practice. All residents with contractures have been reviewed for anti-contraction devices to ensure these are being utilized per order. Occupational therapy has screened all applicable residents not currently receiving active services and requested orders for evaluation and treatment if the screening determined the need. All residents with specific orders for range of motion exercises or other restorative services are receiving services as planned. Documentation is available.</p> <p>Measures to ensure practice does not recur:</p> <p>The ED, DON, and SSD will continue to meet with therapy staff once monthly to review residents currently receiving rehabilitation services, and to discuss residents with status changes that need to be screened. Recruitment efforts are in place for a CNA whose primary responsibility will be restorative nursing duties. A restorative nursing program will be initiated after the restorative CNA receives</p>				

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	<p>indicated the resident was not receiving physical therapy at the time of admission on 2/12/15. The form indicated on 2/13/15, the resident had refused OT (Occupational therapy) three times and when asked to reconsider bilateral splinting for bilateral wrist drop, he indicated he would think about it and asked the Occupational Therapist (OT) to come back at a later time. The OT indicated she would come back on 2/16/15. The resident indicated to come back on 2/18/15, and he would be better. The OT note indicated the therapist came back on 2/16/15, to check with the resident regarding therapy and Hospice was evaluating him to start Hospice. The OT advised the resident and Hospice nurse he would benefit from bilateral splinting for his bilateral wrist drop. The Hospice nurse indicated she would communicate back with the OT about the splints for the residents bilateral wrists. The OT indicated on the note as of 2/16/15, she was awaiting approval from the Hospice nurse for splints for his bilateral wrist drop.</p> <p>During an interview on 6/23/15 at 12:10 p.m., the Administrator indicated she talked to (Name of person) at the Hospice company who indicated she had not placed any braces on the resident or completed any Range of Motion (ROM)</p>		<p>specialized training/education per therapy staff. The DON / designee will be responsible for ensuring that residents who require restorative nursing services are receiving services as planned.</p> <p>This corrective action will be monitored by: A QA audit tool will be utilized 1 time per week x 8 weeks, then once every 2 weeks x 4 months by the DON / designee to review restorative nursing services. Audit results will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>				

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	<p>exercises on the resident for his contractures.</p> <p>During an interview on 6/24/15 at 10:35 a.m., the Administrator indicated the facility did not have a Restorative Nursing Assistant program at that time. She indicated she did not know where the CNA's documented the ROM when they completed it.</p> <p>During a phone interview on 6/24/15 at 5:00 p.m., OT #20 indicated she screened Resident #34 when he was admitted. She indicated she went to his room on 2/13/15, and asked him if she could do an OT evaluation on 2/13/15, but the resident indicated to come back later because he was getting adjusted to the facility. She indicated she told Resident #34 she would be back on 2/18/15. She indicated she came back on 2/16/15, to see the resident and he had already been admitted to Hospice. She indicated before she could do OT on him she had to get Hospice's approval and he needed splinting due to bilateral wrist drop. She indicated Hospice had their own therapy company and the nurse indicated she would get back with OT #20. She indicated the Hospice nurse at that time, told her she would get back with her and to discharge the resident from ST (Speech Therapy) also and Hospice never</p>			

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F 0323 SS=E Bldg. 00	<p>got back with her. OT #20 indicated once the Hospice nurse indicated she would get back with her, then if Hospice did not contact her back, she assumed Hospice was not going to pay for the therapy services because they have their own therapy company, so she did not check back with the Hospice nurse. She indicated when Resident #34 was admitted he only had bilateral wrist contractures and he had bilateral hand contractures now also. She indicated there was a family conference and the resident indicated he wanted off hospice by 7/1/15, so he could go on therapy and he had to be off one service for 30 days before another service could pick him up or else Medicare would not pay for that service, so he would not be able to be picked up for therapy right away.</p> <p>3.1-42(a)(1) 3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to have fall prevention interventions</p>	F 0323	F323 The facility ensures that the resident environment remains as free of accident hazards as is	07/24/2015

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	<p>implemented and root cause analysis 1 of 4 resident reviewed for accidents (Resident #18), failed to ensure an appropriate and safe transfer occurred for 2 of 2 residents being observed for transfers. (Residents #18 and #36) failed to ensure a door to the stairwell was closed and hazardous chemicals were secured. This deficient practice had the potential to affect 9 of 30 residents who were independently mobile.</p> <p>Findings include:</p> <p>1. a. During a staff interview on 6/16/15 at 12:12 a.m., an unidentified nurse indicated Resident #18 had a fall on 6/15/15, due to he had not called for assistance before transferring himself. She indicated he had more than one fall, but that fall was his most recent one.</p> <p>The record for Resident #18 was reviewed on 6/17/15 at 10:00 a.m. Diagnoses included, but were not limited to, aggressive behavior, vascular dementia, cerebrovascular accident, open-angle glaucoma, impulse control disorder, expressive aphasia and legally blind.</p> <p>The resident had a Care Plan dated 10/15/14, which addressed the problem he had the potential for injury from falls</p>		<p>possible, and that each resident received adequate supervision and assistance devices to prevent accidents.</p> <p>Corrective action for residents affected:</p> <p>1. Resident # 18 – An order was obtained for use of a pad alarm while in bed on 7/12/15. The pad alarm was placed on the resident's mattress on this date, and the resident's family / legal representative was notified. The CNA Assignment Sheets and the resident's care plan were updated. The resident's fall risk assessment has been updated.</p> <p>2. Resident #36 – The broda chair has been replaced by hospice with a newer model that is functioning properly. CNA #11 has been educated on operation of any resident equipment currently in use that she is unfamiliar with.</p> <p>3. The door leading from the upstairs to the downstairs was closed upon notification by surveyor that it was ajar. The Maintenance Director inspected the door and adjusted the hinges to ensure proper closure.</p> <p>4. The door to the housekeeping closet was closed and locked upon notification by surveyor that it was open.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged</p>				

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	<p>related to vision status, medications and impaired balance. Approaches included, "10/15/14--Nurses--MENTAL STATUS: Use assistive devices: walker. Request psych consult as needed, Request medical consult: as needed, MOBILITY/CONTINENCE: Request therapy assessment as needed, Use assistive devices: walker, ENVIRONMENTAL: Instruct to call for help. Keep personal items in reach, Provide nonskid footwear. VISION/HEARING: assist with ambulation as needed, keep common areas free from clutter. HISTORY/MEDS/DISEASES: Monitor for behavior changes, Monitor for drug side effects, Assure adequate pain management, report concerns to physician. 10/15/14--Nurse Aide--Call button in reach, Assist with ambulating, transferring, toileting, as needed/requested, Use assistive devices: walker, Report pain indicators, Keep personal items in reach, Nonskid footwear...."</p> <p>The "Falls Investigation Report" provided by the Director of Nursing (DON) on 6/24/15 at 12:30 p.m., and the nurses notes indicated the following:</p> <p>Fall Report on 11/13/14 at 6:26 a.m.- -The resident's fall was unwitnessed. He</p>		<p>deficient practice. Residents with a history of falls or at risk for falls have been reviewed. Appropriate fall prevention interventions were implemented or therapy screens requested. Family members / legal representatives have been notified of any changes in the treatment plan. Care plans and CNA Assignment Sheets have been updated as needed. CNAs have been educated on operation of any resident equipment currently in use that they are not familiar with. All doors that are required to be closed when not in use are monitored and remain closed.</p> <p>Measures to ensure practice does not recur: The facility fall prevention program has been revised to ensure effective and appropriate fall interventions are implemented after a fall has occurred. CNA orientation lists have been revised to include demonstration of resident care equipment. Staff have been re-educated on environmental safety including fall prevention and ensuring doors are closed when no one is accessing them. The Maintenance Director added a weekly inspection of doors for proper closure to the weekly list of preventive maintenance tasks.</p> <p>This corrective action will be monitored by: The corporate nurse consultant will review all residents with falls during routine visits to ensure that</p>	

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	<p>was not identified as a high fall risk at the time of the fall. The resident indicated he "thought" he fell because he was "Going for breakfast." The resident was going to the dining room at the time of the fall and he was confused. His physical status prior to the fall was he had an unsteady gait and he had impaired vision. The report indicated his call button was within reach. No new interventions were listed as being implemented after that fall on that report.</p> <p>Fall Report on 01/23/15 at 10:30 a.m.- -The resident's fall was unwitnessed. He was identified as a high fall risk at the time of the fall. The resident was barefooted at the time of the fall. The resident was getting out of bed when he fell. His physical status prior to the fall indicated his gait was unsteady, he was incontinent and he had impairment of his vision. He mental status was "normal for the resident." The call button was with reach of the resident. No new interventions were listed as being implemented after that fall on that report.</p> <p>Fall Report on 4/12/15 at 10:12 a.m.- -The resident's fall was unwitnessed. He was identified as a high fall risk at the time of the fall. He indicated he was getting up from the wheelchair when he fell. The resident's mental status prior to</p>		<p>the fall prevention program is being followed. Findings will be discussed during exit conferences with the ED, DON, and/or SSD. Non-compliance will be reported to the corporate CEO and immediate corrective action implemented. The CCO / designee will complete environmental rounds and document findings once per week times 3 months, then once every two weeks times 3 months. The CCO will review findings with the ED during exit conferences and immediate corrective action implemented. Compliance reports will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>				

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	<p>the fall was "normal for the resident." The physical status prior to the fall for the resident was he had an unsteady gait and his vision was impaired. The resident indicated he did not have to use the bathroom. No new interventions were listed as being implemented after that fall on that report.</p> <p>Nurses note on 4/12/15 at 10:10 a.m., indicated the resident was found in his room on the floor. He was transferring unassisted with his wheelchair/walker. Action: continue to observe.</p> <p>Nurses note on 4/12/15 at 3:10 p.m., indicated the resident was found in his room on the floor. He was transferring unassisted with his wheelchair/walker. Action: continue to observe. Teaching done: safe transfer techniques.</p> <p>Fall Report on 4/12/15 at 3:15 p.m.--The resident's fall was unwitnessed. He was identified as a high fall risk at the time of the fall. He indicated "I was ready to go eat." He had shoes on his feet. He was going to the dining room at the time of the fall. The mental status for the resident was "normal for the resident." The physical status of the resident was he had an unsteady gait, he was incontinent and his vision was impaired.</p>			

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	<p>Environmental factors at the time of the fall was the resident's call button was not within reach of the resident and his wheelchair was not locked at the time of the fall. The need for re-education for staff indicated no the staff did not need re-educated. No new interventions were listed as being implemented after the fall on that report.</p> <p>Fall Report on 5/22/15 at 2:31 p.m.--The resident's fall was unwitnessed. The report indicated he was a high risk for falls prior to this fall. The resident indicated when he fell he needed to use the bathroom. The resident's footwear at the time of the fall was socks. The resident's activity at the time of the fall was he was getting out of the bed. The mental status for the resident at the fall was "normal for the resident and his physical status was he had an unsteady gait. No new interventions were listed as being implemented after the fall on that report.</p> <p>Nurses note on 5/22/15 at 2:31 p.m., indicated the resident indicated he needed to go to the bathroom and attempted to get up. He only had socks on and his feet slipped out from under him. Actions: continue to observe. Teaching done: resident reminded to use his call light.</p>			

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	<p>Fall Report on 5/24/15 at 5:20 p.m., indicated the resident had an unwitnessed fall and he was identified as a high fall risk before that fall. He indicated he was not hungry, in pain, bored, or had to use the bathroom before he fell. He indicated he was going to the bathroom when he slid and fell on the floor. He had shoes on as footwear. Mental status for the resident was "normal for the resident," but he was unable to follow directions. The resident's call button was within reach, but the floor was wet. The resident was legally blind. The intervention was the resident was reminded to use the call light when he needed to.</p> <p>Nurse note on 5/24/15 at 5:20 p.m., the resident was found in his room. confused and unable to follow directions. He was trying to toilet himself. He indicated he ambulated to the toilet when he fell. His walker was found on the floor next to him. There was no intervention found recorded for that fall in this note.</p> <p>Fall Report on 5/27/15 at 8:50 a.m., the resident had an unwitnessed fall and was identified as a high risk for falls when he fell. He indicated he thought he fell due to he tried to get into bed unassisted. He was not hungry, in pain, bored or needed to be toileted. He had shoes on as</p>			

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	<p>footwear. The resident's activity before he fell was he was getting up from his chair. His mental status was "normal for resident" and he was oriented and confused. His physical status prior to the fall was an unsteady gait, incontinent, he had a visual impairment and his mobility and transfer ability was impaired. The environmental status at the time of the fall was he had his call button within reach, but his wheelchair was unlocked. There was no new intervention to prevent further falls listed on this note.</p> <p>Nurses note on 5/27/15 at 8:50 a.m., indicated the resident was in his room transferring unassisted with his wheelchair. Actions: continue to observe. Teaching done: instructed resident on safe transfer techniques.</p> <p>Fall Report on 6/6/15 at 3:15 p.m., indicated the resident's fall was unwitnessed and he was identified as high risk prior to the fall. He indicated he thought he fell due to he slid out of the bed. He was barefooted when he fell. He was laying on his bed prior to his fall. His mental status prior to the fall was "normal for the resident." The physical status prior to the fall was he had an unsteady gait and impaired vision. The intervention to prevent a future fall was to educate the resident on the proper</p>			

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	<p>positioning while laying in the bed. The report indicated the Care Plan was not updated.</p> <p>Nurses note on 6/6/15 at 3:15 p.m., indicated the resident was found down in his room. confused when found. He had been laying down in bed and he slid out of his bed. He indicated he slipped on the floor. Actions: continue to observe. Teaching done: instructed resident on use of call light and to lay in the middle of the bed when in it.</p> <p>Nurses note on 6/15/15 at 3:45 p.m., indicated the resident was in his room. transferring unassisted with his wheelchair. Actions: continue to monitor. Teaching done: instructed resident on safe transfer techniques and use of call light.</p> <p>There were no new prevention interventions and no root cause analysis as to the cause of the resident's falls located in the resident's record. Documentation after each fall indicated the facility failed to implement preventative measure.</p> <p>On 6/24/15 at 10:46 a.m., the fall prevention interventions implemented after each fall to prevent future falls for this resident was requested from the</p>			

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	<p>Director of Nursing (DON).</p> <p>A document dated 6/24/15, provided by the DON dated 6/24/15, indicated the resident's fall interventions included: non-skid slippers were to placed on the resident at all times while he is in bed. His shoes were to be on while he was up in his wheelchair.</p> <p>On 6/17/15 at 11:15 a.m., the resident was laying in bed, then sat up on the side of the bed. He laid back down and covered up his head with the sheet and blanket on his bed. The resident had a wheelchair that was sitting at the foot of the bed with his walker away from the bed. He had a gray mat leaning up against the wall at the foot of his bed. His bed was against the wall. His black shoes were laying on the floor in front of his bed and he had on white socks.</p> <p>On 6/17/15 at 4:31 p.m., the resident was laying in bed covered with blankets with his feet sticking out of the blankets with white socks on. His bed was against the wall. His wheelchair was sitting by the foot of his bed with his walker. There was a gray mat leaning up against the wall at the foot of the bed. His head was covered up with his sheet.</p> <p>On 6/18/15 at 8:36 a.m., the resident was</p>			
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	<p>laying in bed with white socks on. His head was covered with his sheet.</p> <p>On 6/19/15 at 9:59 a.m., the resident was laying in his bed with white socks on with his head uncovered watching his room mate's TV.</p> <p>On 6/19/15 at 2:25 p.m., the resident was laying in his bed with white socks on with a gray flat mat laying folded in half under his bed. He was laying with the sheet covering his head.</p> <p>On 6/24/15 at 12:37 p.m., the resident was observed being dressed by CNA #13 with white socks on his bilateral feet.</p> <p>During an interview on 6/17/15 at 11:23 a.m., RN #2 indicated the resident was not able to use his call light to ask for assistance and he had attempted to get up unassisted especially around mealtime. She indicated if he heard people walking down the hallway, he would yell at people to come into his room to get him up into his wheelchair.</p> <p>During an interview on 6/19/2015 at 2:30 p.m., LPN #3 indicated the resident had white socks on and he either wore these white socks or he would take them off himself and go barefooted. She indicated he was supposed to have the flat gray mat</p>			

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	<p>beside his bed when he was in bed and he did not have the mat next to his bed at that time.</p> <p>b. On 6/24/15 at 12:37 p.m., Resident #18 was observed being dressed by CNA #13. She indicated at that time, this was the first time she had taken care of this resident and she did not know how to take care of him and he did not want to roll him to get his clothes on. CNA #13 was observed to be having difficulties trying to turn the resident by her self and the resident was close to the edge of the bed by the side of the bed, which was not against the wall while she was attempting to pull his pants up.</p> <p>On 6/24/15 at 12:43 p.m., LPN #3 came into Resident #18's room and assisted CNA #13 to get the resident dressed, then she assisted CNA #13 to transfer the resident into his wheelchair. LPN #3 and CNA #3 was observed transferring the resident by sitting him up on the side of the bed, then each one of them placed an arm under his arms and stood him up with his walker in front of him. CNA #13 went behind the resident's wheelchair LPN #3 assisted the resident to pivot by holding onto his arm and CNA #13 held onto the back of his pants at the buttock area to assist him to pivot. The resident was unsteady on his feet and wobbled</p>			
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	<p>while he was pivoting. He grabbed a hold of the wheelchair handles and sat down in the wheelchair as CNA #13 was guiding him down into the wheelchair by the seat of his pants.</p> <p>During an interview on 6/24/15 12:50 p.m., CNA #13 indicated she worked for the agency and today was her first day at this facility. She indicated she should have used a gait belt to transfer this resident into his wheelchair, but she did not have one and she was not supplied with a gait belt from the agency she was employed by. CNA #13 indicated the facility did not give her a gait belt to use when she came into work at the facility today and she did not ask for one. She was observed to get out her CNA assignment sheet, at that time and after she reviewed it CNA #13 indicated her CNA assignment sheet indicated she was to use a gait belt for all transfers and ambulation assists. She indicated some facilities provide gait belts when she went into them to work and some did not, but she had not been here at this particular facility before. She indicated this resident was a large man and if he had fallen during the transfer she had done, there would not have been any way to grab a hold of him to prevent his fall or help ease him to the floor.</p>			

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	<p>During an interview on 6/24/15 at 1:50 p.m., CNA #9 indicated there were gait belts located at the nurses station for any staff member who needed a gait belt. She indicated she did not inform agency staff when they came into the facility for the first time the gait belts were located at the nurses station, if they did not have one of their own.</p> <p>At the end of the Exit Conference on 6/24/15 at 7:15 p.m., the Gait Belt policy had not been provided that was requested from the DON on 6/23/15.</p> <p>A current policy titled "Falls and Fall Risk, Managing" dated December 2007, provided by the DON on 6/24/15 at 12:30 p.m., indicated "Policy Statement: Based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation: Prioritizing Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize</p>			

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	<p>interventions (i.e., to try one or a few at a time, rather than many at once)...4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 6. In conjunction with the Attending Physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable to try to minimize serious consequences of falling.)"</p> <p>2. On 6/18/15 12:05 p.m., Resident #36 was transferred from her chair to her bed with CNA #11, CNA #9 and the Administrator. CNA #11 indicated at that time, she was the CNA that had just gotten here at the facility because she had not realized she was scheduled to work today and she had only been employed here at the facility for six days. The two CNA's placed the sling back under the resident by rolling her from side to side in the chair.</p>			

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	<p>The Administrator stood and observed the aides while they placed the sling under the resident. The resident cried while they were placing the sling under her for a few seconds. CNA #11 indicated she did not know how to put the foot of the geri chair down while she was trying to put the foot of the geri chair down, then the foot of the geri chair slammed down. The resident was sitting straight up in the geri chair at that time. The hoyer lift was pushed over towards the resident by the Administrator and the bars of the hoyer lift was placed over the resident's chest/abdominal area to enable the two CNA's to secure the straps of the sling to the hooks of the bars.</p> <p>The CNA's took the straps off the hooks and attempted to place the straps on the hooks again. The administrator came to the head of the geri chair and asked if the CNA's had the correct sling. While the CNA's were attempting to secure the straps to the hoyer hooks on the bars the resident began sliding out of the geri chair. The Administrator instructed the CNA's to lay the geri chair back and she went to the foot of the geri chair to raise it. The CNA's took the straps off the hooks of the hoyer lift, then the Administrator and both CNA's pulled Resident #36 back up in the geri chair. Both CNA's resecured the straps on the</p>			
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	<p>hooks with the resident laying down in the chair. CNA #9 operated the hoyer lift while CNA #11 and the Administrator were the two spotters holding onto the resident under her bottom and guiding her over to the bed.</p> <p>CNA #9 guided the hoyer and operated the hoyer lift, while the Administrator and CNA #11 centered the resident in the middle of the bed as she was being lowered. A black flat mat was in front of the bed and CNA #9 had to move the mat before she could continue guiding the resident over towards the bed while in the hoyer lift.</p> <p>Resident #36's record was reviewed on 6/22/15 at 9:50 a.m. Diagnoses included, but were not limited to, anxiety, senile psychosis, dementia, brain meningiomas removed, and mood disorder adjustment with depressed mood.</p> <p>A physician order dated 6/4/15 indicated "Clarification: All transfers to be completed by Hoyer secondary to maximum times two assist due to non-ambulatory.</p> <p>During an interview on 6/19/15 10:00 a.m., CNA #11 indicated on 6/18/15, when she was trying lower Resident #36's</p>			

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	<p>foot of the geri chair and it slammed down she did not know which lever to pull to make the foot of the chair come down. She indicated there were two levers on the geri chair and she had not used one of those kinds of geri chairs before, so she did not know, whether it was the top or bottom lever and when she found the correct lever it slammed down and it even scared CNA #11 when it slammed down.</p> <p>On 6/22/15 12:14 p.m., the Administrator indicated she did not see a concern with the transfer of Resident #36 when the hoyer lift transfer was performed on 6/18/15.</p> <p>A current policy titled "Safe Lifting and Movement of Residents" dated December 2013, provided by the DON on 6/24/15 at 5 p.m., indicated "Policy Statement: In order to protect the safety and well-being of staff and resident's, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation:..4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices... 6. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and</p>			

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	<p>procedures regarding use of equipment and safe lifting techniques...11. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which...c. Provides training on safety, ergonomics and proper use of equipment...."</p> <p>3. On 06/23/2015 at 2:06 p.m., an observation was made of the door leading from the upstairs to the downstairs being ajar. At the time of the observation the DON (Director of Nursing) and SSD (Social Services Director) were coming up the stairs.</p> <p>On 6/23/15 at 2:06 p.m., the DON indicated she saw the door was ajar and it should be closed.</p> <p>4. On 06/24/2015 at 12:54 p.m., an observation was made of an open closet next to the DON's office. Chemicals labeled floor cleaner, glass cleaner, sink toilet and shower cleaner, air freshener, all purpose cleaner, clean air order eliminator, stainless steel polish, and WD 40 were observed in the open closet. The WD 40 label stated "...If SWALLOWED; Immediately call a POISON CENTER or physician..."</p> <p>On 06/24/2015 at 12:57 p.m., the DON indicated she did not know if the closet door should be open but stated when in</p>			

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F 0325 SS=G Bldg. 00	<p>doubt close it.</p> <p>A current facility policy provided by the Administrator on 06/23/15 at 3 p.m., titled, "Resident Rights" dated 1997, indicated: "Environment...The facility must provide 1. A safe, clean comfortable and homelike environment..."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to recognize a significant weight loss and implement prevention interventions in a timely manner to prevent a resident from experiencing significant weight loss (Resident #18) for 1 of 3. Resident #18 experienced a 12.3% weight loss in 180 days.</p>	F 0325	<p>F325 The facility ensures that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.</p> <p>Corrective action for residents affected: Resident #18 was weighed for on</p>	07/24/2015
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	<p>Findings include:</p> <p>Resident #18's record was reviewed on 6/17/15 at 10:00 a.m. Diagnoses included, but were not limited to, aggressive behavior, vascular dementia, Diabetes Mellitus, iron deficiency anemia, and impulse control disorder.</p> <p>The resident's Recapitulation of physician orders dated June 2015, included, but were not limited to, the following orders: 8/14/14--Regular diet with double portions. 11/20/14--House shake three times a day with meals at 8 a.m., 12 p.m. and 5 p.m.</p> <p>The following were the resident's meal intakes from March 2015 through June 2015, for each meal: BREAKFAST--75-100% LUNCH--75-100% DINNER--75-100%</p> <p>The resident's weight record indicated: 12/10/14--229 1/28/15--220 2/25/15--220 3/17/15--223 4/24/15--215 5/7/15--224 6/1/15--204</p> <p>The resident's weight losses in the last</p>				<p>6/24/15 and a weight of 235 was obtained. Weights were continued for three consecutive days; weight recorded on 6/26/15 at 234. The DON consulted with the facility RD and the medical director regarding the resident's weight. Weekly weights were ordered and are being completed per order. The care plan has been updated.</p> <p>Other residents having the potential to be affected and corrective actions: All residents at risk for weight loss have the potential to be affected by this alleged deficient practice. Residents are weighed at least once monthly unless ordered more frequently by the attending physician. All weights obtained since 6/24/15 have been reviewed by the DON and a re-weight obtained for any unplanned variance greater than five pounds from the previous weight. The consultant RD has reviewed all unplanned weight losses or gains since 6/24/15 and made recommendations to ensure optimum parameters of nutritional status are maintained. A facility-wide audit was conducted and a list of all residents with planned supplements compiled. Meal cards were updated to reflect all current planned supplements.</p> <p>Measures to ensure practice does not recur: A new system for monitoring room tray delivery and dining</p>		

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	<p>180 days from 12/10/14 to 6/1/15: He lost 20 pounds in less than 30 days for 9.8% significant weight loss. He lost 19 pounds in 90 days for 9.3% significant weight loss. He lost 25 pounds in 180 days for 12.3% significant weight loss.</p> <p>The resident's current laboratory results included, but was not limited to, the following: 6/9/15-- Albumin (indication of protein and overall nutrition): 3.2 L- Normal 3.5-5.5 g (gram) /dL (decaliter)</p> <p>3/25/15-- Albumin--3.1 L</p> <p>The resident's Physician progress notes indicated the following: 12/30/14--indicated there was no weight documented for this visit. 1/26/15--indicated the resident's weight was 229 3/23/15--indicated the resident's weight was 225. 4/2/15--indicated the physician was visiting the resident for the complaint of dementia. Weight documented on form as 225</p> <p>The resident had a Care Plan dated 10/15/14, which addressed the problem</p>		<p>services including supplements offered and assistance with eating has been implemented. A licensed nurse / QMA or department head is designated each meal to complete a written observation of the above program. The ED or DON is responsible for reviewing compliance with the program. Education has been provided to persons responsible for monitoring the program.</p> <p>This corrective action will be monitored by: A QA audit tool will be utilized 1 time per week x 8 weeks, then once every 2 weeks x 4 months by the CCO / designee to ensure compliance with the nutrition program. Audit results will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>		

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	<p>he had the potential for unintended weight loss related to agitation, impaired vision and aphasia, 2/25/15 related to inadequate food intake, depression and confusion and involuntary weight loss of 10% in the past 6 months. Approaches included "10/15/14---"...weight monthly and as needed... report concerns to the physician... 2/25/15--Nurses---Weights as ordered, Provide supplements as ordered...Avoid interruption of mealtimes, 10/15/14--Nurse Aide--Obtain weights as assigned, Assist to eat as needed, Set up foods as needed...2/25/15--Nurse Aides--...Provide cues and encouragement... 2/25/15--Dietary---...Dietary consult...."</p> <p>On 6/18/15 at 8:58 a.m., the resident was lying in bed and had not received his room tray for breakfast.</p> <p>During an interview on 6/18/15 at 8:59 a.m., the Director of Nursing (DON) indicated if he had his head covered up that meant to leave him alone and he had probably refused to eat.</p> <p>During an interview on 6/18/15 at 9:01 a.m., LPN #3 indicated the CNA's were the persons who passed the breakfast trays and to ask one of them who passed his breakfast tray.</p>			

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	<p>During an interview on 6/18/15 at 9:03 a.m., CNA #10 indicated she did not pass his breakfast tray and she did not know if he refused his tray or not because there was only two CNA's, so they both had all the residents.</p> <p>During an interview on 6/18/15 at 9:04 a.m., Cook #8 indicated she did not know he had not come to the dining room for breakfast and needed a room tray, so she did not fix him one. She indicated the CNA's were supposed to give her a list of the room trays, so she was able to fix the resident's room trays. She indicated she did not know he was not coming to the dining room, but she would fix him a room tray right now. Cook #8 went to CNA #10 at that time, and told her she was fixing the resident a tray and she would let her know when the tray was ready.</p> <p>On 6/18/15 at 9:13 a.m., the resident's tray was delivered. He was given double portions of scrambled eggs, bacon, toast, supercereal and blueberries. He was given water, orange juice and milk to drink. He requested the DON, who delivered his tray to feed him. The DON did assist and encouraged him to help himself by handing him the fork with food on it. He tasted his blueberries and indicated he did not like them. There was</p>			

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	<p>no house shake observed on his tray nor did he get one during his meal time.</p> <p>During an interview on 6/18/15 at 9:18 a.m., CNA #9 indicated she did not know the resident was not given a room tray because she was feeding another resident in his room and she did not know there was only two CNA's here to care for the residents. She indicated she thought there was three CNA's here this morning.</p> <p>On 6/18/15 at 9:58 a.m., the resident ate 90% of his breakfast and drank his milk and orange juice. He did not eat his supercereal or his blueberries. The DON indicated at that time, the resident was a meat and potato man and he only wanted meat and potatoes and he would not eat his supercereal.</p> <p>During an interview on 6/18/15 at 10:00 a.m., CNA #10 indicated by this resident not getting his room tray was a miscommunication because there was only two CNA's working on the floor today and there should have been three CNA's, so neither of them knew he was not fed his breakfast. She indicated if he was not fed when his tray was set down in front of him he would knock his tray off the table. She indicated she usually fed him as soon as he got his tray, then she took him back to his room and placed</p>			

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	<p>him back in his bed.</p> <p>During an interview on 6/22/15 at 12:14 p.m., the Administrator with the DON present, the Administrator indicated she was not aware the resident had a 12.3% weight loss in 180 days, but she would look in the resident's record and get what information she could find on his weight loss.</p> <p>A document dated 6/22/15, provided by the Administrator on 6/23/15 at 12:10 p.m., indicated "Reviewed surveyor's concern that [name of resident] has lost weight. His current weight is 204 pounds and his height is 6 feet four inches. This computes to a BMI [Body Mass Index] of 24.8 which falls within the normal range of 18.5-25. This information was shared with [Name of physician]. At this time he is not concerned about resident's weight loss as it appears to be a 'healthy' weight loss. We have order to continue to monitor by weighing resident weekly and reporting any further weight loss to MD."</p> <p>On 6/24/15 at 12:50 p.m., the Activities Director was assisting the resident by feeding him his lunch meal. He had smoked sausage, sauerkraut, mashed potatoes, yellow squash, and pink cake for his lunch. He had cranberry juice in</p>			
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	<p>two glasses and water to drink. There was no house shake given to the resident with his meal. The resident's meal card indicated he was to have a regular diet with double portions. He ate 75% of his lunch, then he started becoming impatient while waiting for his hamburger to be cooked by the kitchen staff twice and began rolling himself away from the table. The Activities Director got the hamburger for the resident and cut it in half for him and he fed himself his sandwich. Whenever the Activities Director left the table to go get someone else something the resident tried to wheel himself away from the table.</p> <p>During an interview on 6/24/15 at 1:33 p.m., LPN #14 indicated the resident received his houseshake from the kitchen at 8 a.m., 12 p.m., and 5 p.m., with his meals. She indicated this was the first day she had taken care of him, so she would have to ask the kitchen and if he got the houseshake at his lunch meal because she checked with the kitchen this morning regarding the house shake and he had received it with his breakfast.</p> <p>During an interview on 6/24/15 at 1:36 p.m., Cook #8 indicated it was up to the CNA's to ask for the house shakes (mighty shakes). She indicated this resident had not been receiving his</p>			

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	<p>mighty shakes because mighty shakes were not listed to be given to him with his meals on his meal card. She indicated he had been taken off the mighty shakes at some point, so they were removed off his meal card and when they were reordered, the mighty shakes did not get placed placed back on his meal card, so he had not been receiving them and she could not indicate how long he had been without his mighty shakes.</p> <p>During an interview on 6/24/2015 at 1:47 p.m., the DON indicated the last weight done on Resident #18 was on 6/1/15 and she had not contacted the Registered Dietician regarding this resident's significant weight loss.</p> <p>During an interview on 6/24/15 at 2:16 p.m., the Administrator indicated at that time, she was going to look at the scales to make sure they were calibrated since he weighed 253 pounds in October 2014 and on 6/1/15, he weighed 204, which was a 49 pound weight loss in 10 months and he had a 20 pound weight loss in the last month. The Administrator indicated she would recheck his weights as well. She indicated the Registered Dietician visits every two weeks for at least 4 hours. She indicated the last time the Registered Dietician visited the resident was on 3/24/15 and 6/2/15 and she would</p>			

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	<p>provide the Dietician notes for those visits.</p> <p>There were no Registered Dietician assessment notes found in his record. No Registered Dietician assessment notes were provided by the end of the exit conference on 6/24/15 at 7:15 p.m., when they were requested on 6/24/15.</p> <p>A current policy titled "Dietitian" dated March 2010, was provided by the DON on 6/24/15 at 12:30 p.m., indicated "Policy Statement: A qualified Dietitian will help oversee clinical nutritional Dietary Services in the facility. Policy Interpretation and Implementation: 1. A qualified Dietitian will help oversee clinical nutritional services to the resident's. A Food Services Manager will oversee the production, storage, and delivery of food...."</p> <p>A current policy titled "Facility Nutrition Program" dated April 2007, provided by the DON on 6/24/15 at 12:30 p.m., indicated "Policy Statement: The facility will have an organized nutrition-related program. Policy Interpretation and Implementation:...3. A facility Dietitian will help assess the nutritional needs and risks of all residents and patients in the facility, and help the facility assure that it provides appropriate meals and other</p>			

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F 0329 SS=D Bldg. 00	<p>nutritional interventions... 5. The facility Administrator will ensure the effective coordination of the disciplines and related activities involved in the facility's clinical nutrition program. 6. As part of the facility's quality improvement program, the staff, Administrator, and Medical Director will review nutrition-related outcomes and address related problems."</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue</p>			

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	<p>these drugs.</p> <p>Based on interview and record review, the facility failed to monitor for specific targeted behaviors for the use of psychoactive medications for 5 of 5 residents reviewed for unnecessary medications. (Residents #1, #3, #26, #28, and #24)</p> <p>Findings include:</p> <p>1. On 6/17/15 at 9:21 a.m., the record review for Resident #28 was completed. Diagnoses included, but were not limited to, radiation necrosis of the brain, psychosis and depressive disorder, polysubstance abuse, and delusions.</p> <p>The physician's orders indicated: 8/18/14- Risperidone (antipsychotic medication)1.5 milligrams (mg) by mouth twice daily 5/15/15- Ambien (a sleep medication) 5 milligrams</p> <p>The Social Service notes from November 2014 through June 2015 indicated: 11/14/14-"... the resident said two aides came into his room in the middle of the night the other night and that one of the aides was being really nice and the other aide wanted to sell him to the highest bidder of women waiting outside his room and that the other aide dipped his</p>	F 0329	<p>F329</p> <p>The facility ensures that reach resident's drug regimen is free from unnecessary drugs, and that residents who have not used antipsychotic drugs are not given these drugs unless the therapy is necessary to treat a specific condition. Residents who receive antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated in an effort to discontinue these drugs.</p> <p>Corrective action for residents affected:</p> <p>1. Resident #28 – Behavior monitoring has been initiated for the use of Risperidone and Ambien. Documentation is available.</p> <p>2. Resident #1 - The Zyprexa was discontinued on 6/22/15. There are no additional psychopharmacological medications prescribed for the resident, so no behavior monitoring is required at this time.</p> <p>3. Resident #3 – Resident #3 has been discussed by the IDT and behaviors that justify the need for the use of Seroquel have been identified and are now being documented.</p> <p>4. Resident #34 has been discussed by the IDT and behaviors that justify the need for the use of Risperidone, Diazepam, and Lorazepam.</p> <p>5. Resident #26 – Behavior monitoring is being documented</p>	07/24/2015			

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	<p>hand in urine and made him rub it all over himself so he would be undesirable Resident said he didn't realize at the time what he was thinking wasn't reality but that he understood now that is [sic] wasn't real. Resident also described a vivid dream he had regarding a trip he had to take with a team of people to find 'true representation' of the facility At the end of the interview the resident went back to the delusion and asked the SSD (Social Services Director) how he could go about 'the trip'..."</p> <p>2/9/15-"...Per conversation during MDS (Minimum Data Set) interview on 2/6, resident told SSD that another resident had died. When SSD asked for further information, resident described looking through the bottom of his glass at breakfast and seeing a sequence of numbers. Resident said when he figured out what the numbers were telling him it was that another resident was dead...."</p> <p>The Behavior Monitoring book had an undated document which identified the resident had a behavior of voiding in public places and delusions. The sheet was blank.</p> <p>The Behavior Intervention Monthly Flow Records for February, March, May and June 2015 indicated the resident had no behaviors.</p>		<p>for behaviors related to the use of Haldol Decanoate injection.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents receiving psychopharmacological agents have the potential to be affected by this alleged deficient practice. The SS consultant has assisted the DON, the corporate nurse consultant, and the SSD with review of all applicable residents and medications. Appropriate behaviors that require monitoring have been identified and care plans updated as deemed necessary.</p> <p>Measures to ensure practice does not recur:</p> <p>All staff was educated on the need to document observed behaviors that could place the resident or other residents at risk for harm, or that are indicators of significant distress to the resident. Behavior incidents are reviewed daily during the morning meeting Monday through Friday. The Behavior Team will continue to meet monthly with the psychiatrist who oversees residents with mental health diagnosis, and review each resident's mood and behaviors. Minutes of each meeting are maintained.</p> <p>This corrective action will be monitored by:</p> <p>A QA audit tool will be utilized once per week x 8 weeks by the SSD / designee to review behavior documentation. The</p>				

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	<p>On 6/24/15 at 9:25 a.m., the SSD indicated Resident # 28's delusions were not specific. She indicated the delusions he had voiced have been all over the place. She indicated she had shared with the Interdisciplinary Team at the Behavior Monthly Meetings what delusions the resident was having. She indicated she could not recall sharing the specific delusions/behaviors of Resident #28 with the staff that she could recall. She indicated the delusions were not specific as to what should be monitored on the behavior monitoring sheets. She indicated there was no monitoring insomnia or night-time behavior for the use of the Ambien.</p> <p>2. On 6/17/15 at 9:21 a.m., the record review was completed on Resident #1 . Diagnoses included, but were not limited to stroke, traumatic brain injury, dementia and depression.</p> <p>The Recapitulation of Physicians orders for June 2015 indicated the resident was on Zyprexa 2.5 milligrams (mg) 1 tablet by mouth daily for intermittent explosive disorder with original order date of 10/27/14.</p> <p>The nurses notes indicated:</p>		<p>corporate nurse consultant /designee will review all minutes from morning meetings and audit behavior documentation during routine visits also. Findings will be discussed during exit conferences with the ED, DON, and/or SSD. Audit results will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>		

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	<p>10/28/14-Medication changes identified and next 7 days and no adverse effects noted. No agitation or aggression noted as well as no issues noted with recent medication reduction. no change of behavior noted.</p> <p>11/4/ and 11/5/14- No agitation or increased in behavior</p> <p>11/29/14-No behavior issues noted at this time will continue to monitor resident.</p> <p>1/2/15- No behavior issues noted</p> <p>1/7/15:-AIMS done no concerns</p> <p>1/12/15- No behavior concerns noted</p> <p>1/24/15- indicated no behavior issues and appears psychologically well adjusted at all times No behavior issues</p> <p>1/31/15- no behavior issues none occurred in last 7 days</p> <p>2/7/15- No behavior issues</p> <p>2/14/15- No behavior issues</p> <p>2/21/15- No behavior issues</p> <p>The nurses notes dated March 2, 2015 resident became upset with debris on floor in the dining room and left the dining room and refused to eat. The staff documented that he was short tempered and irritable and they did one on one, assessed for pain, activity, changed position, offered conversation, warm milk and food given, offered a distracting activity, reassured, reoriented, toileted, and as needed medication and the outcome was improved mood.</p>			

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	<p>The Behavior Book indicated the drug the resident was on was Zyprexa 2.5 milligrams for the behavior history of throwing the food in the dining room. The sheet was blank.</p> <p>The June 2015 Behavior/Intervention Monthly Flow Record indicated: History of throwing things in dining room. Interventions: Redirect, offer choices, anticipate needs.</p> <p>The MD Progress notes from the facility physician were reviewed from January 2015 through June 2015 and the notes had no indication of behavior concerns.</p> <p>The psychiatric MD progress notes dated 11/2/14, 12/7/14, 1/15/15, 2/13/15, 3/12/15, 4/7/15, 5/5/15, and 6/2/15 all indicated Behavior and Mood Stable. The Psych MD had checked the box marked Vascular Dementia with delusions.</p> <p>The Behavior Documentation indicated: February 2015 : history of throwing food in dining room. Interventions: 1) Redirect 2. 1 on 1. 12. Offer choices 13. Anticipate/meet needs. April 2015 : history of throwing food in dining room. Interventions: 1) Redirect 2. 1 on 1. 12. Offer choices 13.</p>			
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	<p>Anticipate/meet needs.</p> <p>May 2015 history of throwing food in dining room. Interventions: 1) Redirect 2. 1 on 1. 12. Offer choices 13.</p> <p>Anticipate/meet needs.</p> <p>June 2015: Hx (history) of throwing things in dining room. Interventions: Redirect, offer choices, anticipate needs.</p> <p>There were no documented behaviors located for this resident from October 2014 through June 2015.</p> <p>On 6/22/15 at 3:10 p.m., during interview with the Medical Director, he indicated Resident #1 had diagnoses of delusional disorder and had a history of getting very aggressive. He indicated he had not seen that. The Medical Director indicated he deferred the psychotropic drug information to the psychiatrist and the psychiatrist had the final decision in dosage of psychiatric medications.</p> <p>On 6/22/15 at 3:25 p.m., during an interview with the Medical Director, he indicated that the psychiatrist had indicated via phone discussion that the medication could be discontinued due to no behaviors.</p> <p>3. Resident #3's record was reviewed on 6/17/15 at 3:02 p.m. Diagnoses included, but were not limited to, bi-polar with psychotic features, anxiety, and</p>			

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	<p>dementia with behavioral/agitation.</p> <p>The resident's Recapitulation of physician orders (Recap) dated June 2015, included, but were not limited to, the following orders: 9/22/14--Quetiapine Fumarate (an anti-psychotic medication) 100 mg take one tablet by mouth daily at bedtime for bipolar with psychotic features. 9/22/14--Quetiapine Fumarate 50 mg take one and one-half tablets (75 mg) by mouth daily in the morning for bipolar with psychotic features.</p> <p>The resident's "Behavior/Intervention Monthly Flow Record" dated February 2015 through June 2015, included, but were not limited to, the following behaviors: "Physical Aggression" "Yelling/Cursing" "Refuses Care"</p> <p>The "Documented Behaviors" dated February 2015, indicated the resident had no behaviors for this particular month that had been discussed in the behavior meeting.</p> <p>The "Documented Behaviors" dated March 2015, indicated the resident had 1 episode of "Yelling/cursing."</p> <p>The "Documented Behaviors" dated April 2015, indicated the resident had 1</p>			

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	<p>episode of "physical aggression", 1 episode of "yelling/cursing" and 1 episode of "refusing care." The "Documented Behaviors" dated May 2015, indicated the resident had 1 episode of "yelling/cursing." The "Documented Behaviors" dated June 2015, had not been compiled as of the date the resident's record was reviewed.</p> <p>A Geriatric Psychiatry Progress note dated 1/5/15, indicated "Diagnosis: Senile Dementia with delusional features... Chief complaint: None... History of Present Illness. Patient was evaluated for: Dementia, Delusions, Irritability, Anxiety, Agitation...Mental Status Examination:...Thought Content: Delusions: No [No box was checked]... Hallucinations: No [No box was checked]... Summary of the finding: Behavior mood Stable... Treatment Plan: Continue Current Treatment...."</p> <p>A Geriatric Psychiatry Progress note dated 2/13/15, indicated "Diagnosis: Bipolar I disorder, most recent episode (or current) mix moderate... Chief complaint: None... History of Present Illness. Patient was evaluated for: Dementia, Delusions, Irritability, Anxiety, Agitation...Mental Status Examination:...Thought Content: Delusions: Paranoid [Paranoid box was</p>			

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	<p>checked with no further boxes checked to describe the paranoia]... Hallucinations: No [No box was checked]... Summary of the finding: Behavior mood Stable... Treatment Plan: Continue Current Treatment.... Other-No med reductions indicated at this time."</p> <p>A Geriatric Psychiatry Progress note dated 3/12/15, indicated "Diagnosis: Bipolar I disorder, most recent episode (or current) mix moderate... Chief complaint: None... History of Present Illness. Patient was evaluated for: Dementia, Delusions, Irritability, Anxiety, Agitation...Mental Status Examination:...Thought Content: Delusions: No [No box was checked]... Hallucinations: No [No box was checked]... Summary of the finding: Behavior mood Stable... Treatment Plan: Continue Current Treatment...."</p> <p>A Geriatric Psychiatry Progress note dated 4/7/15, indicated "Diagnosis: Bipolar I disorder, most recent episode (or current) mix moderate... Chief complaint: None... History of Present Illness. Patient was evaluated for: Dementia, Delusions, Irritability, Depression, Agitation...Mental Status Examination:...Thought Content: Delusions: No [No box was checked]... Hallucinations: No [No box was</p>			

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	<p>checked]... Summary of the finding: Behavior mood Stable... Treatment Plan: Continue Current Treatment...."</p> <p>A Geriatric Psychiatry Progress note dated 5/2/15, indicated "Diagnosis: Bipolar I disorder, most recent episode (or current) mix moderate... Chief complaint: None... History of Present Illness. Patient was evaluated for: Dementia, Delusions, Irritability, Anxiety, Agitation...Mental Status Examination:...Thought Content: Delusions: No [No box was checked]... Hallucinations: No [No box was checked]... Summary of the finding: Behavior mood Stable... Treatment Plan: Continue Current Treatment...."</p> <p>During an interview on 6/24/15 11:45 a.m., the Social Service Director (SSD) indicated Resident #3's Quetiapine Fumarate was ordered for the behaviors, which was listed on his behavior monitoring sheets, which were physical aggression, yelling/cursing and refusal of care. These behaviors do not meet the justification for the use of an antipsychotic.</p> <p>4. Resident #34's record was reviewed on 6/17/15 at 12:50 p.m. Diagnoses included, but were not limited to, anxiety disorder, affective personality disorder,</p>			

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	<p>and bipolar.</p> <p>The resident's Recapitulation of physician orders dated June 2015, included, but were not limited to,</p> <p>2/11/15--Risperidone (an anti-psychotic medication) 1 mg take one tablet by mouth twice daily.</p> <p>2/24/15--Diazepam (an anti-anxiety medication) 5 mg take one tablet by mouth every six hours PRN (as needed) for anxiety.</p> <p>2/25/15--Trazodone (an antidepressant) 150 mg take one tablet by mouth daily at bedtime for insomnia.</p> <p>3/3/15--Lorazepam (an anti-anxiety medication) 0.5 mg tablet take one-half tablet (0.25 mg) by mouth twice daily for agitation.</p> <p>4/7/15--Duloxetine HCL (Hydrochloride) DR (delayed release) (an antidepressant medication) 60 mg take one capsule by mouth daily for depression.</p> <p>The resident's "Behavior/Intervention Monthly Flow Record" dated February 2015 through June 2015, included, but were not limited to, the following behaviors:</p> <p>"Attention Seeking Behavior"</p> <p>"Social Isolation"</p> <p>"False Accusations"</p> <p>The "Documented Behaviors" dated</p>			
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	<p>February 2015, indicated the resident had 7 episodes of "Attention seeking bx [behavior] (yelling/screaming for staff)." indicating there was 1 episode on dayshift, 4 episodes on evening shift and 2 episodes on night shift.</p> <p>The "Documented Behaviors" dated March 2015, indicated the resident had 10 episodes of "Attention seeking/yelling out."</p> <p>The "Documented Behaviors" dated April 2015, indicated the resident had 18 episodes of "attention seeking behaviors."</p> <p>The "Documented Behaviors" dated May 2015, indicated the resident had 5 episodes of "attention seeking behaviors."</p> <p>The "Documented Behaviors" dated June 2015, had not been compiled as of the date the resident's record was reviewed.</p> <p>A "Diagnostic & Mental Status Examination Report" dated 3/20/15, "...Current Psych Diagnosis: Anxiety and Affective Personality Disorder... Diagnostic Evaluation Results... consistently depressed mood + [and] poor sleep... He denied anxiety symptoms. No psychosis present... Recommendations: 1) suggest starting Cymbalta [an antidepressant medication] 30 mg q (every) am. 2) Will continue to follow c with a line over it [with] behavior monitoring and Management Psychological review."</p>			

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	<p>A" Psychotherapy/Behavior Therapy" Progress Note dated 5/4/15-- indicated "...Purpose of Therapy: Signs/ S & S [Sign and Symptom] of depression. Adjustment to ECF [Extended Care Facility] ... Staff Reports: frequent yelling. Patient reports: periodic depression, unable to explain yelling... Recommendations: Suggest increased Depakote ER to 750 mg q [every] am...."</p> <p>During an interview on 6/24/15 at 11:45 a.m., the SSD indicated the behavior being monitored for this resident for Diazepam and Lorazepam was Attention seeking due to he became anxious, then he yelled out for attention. She indicated the behaviors being monitored for the Risperidone was whatever his diagnosis was for the medication. She indicated the behaviors for the Duloxetine was for depression and Trazodone was for insomnia. She indicated there was no specific justified targeted behaviors for the use of Risperidone, Diazepam and Lorazepam.</p> <p>5. On 06/17/2015 at 3:55 p.m., the record review for Resident #26 was completed. Diagnoses including, but were not limited to, dementia (alcohol induced), auditory hallucinations and history of substance abuse.</p>			

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	<p>A MDS (Minimum Data Set) assessment dated 4/04/15 indicated a BIMS (Brief Interview for Mental Status) of 10 indicating moderate cognitive impairment. The MDS also indicated that the resident was always continent.</p> <p>A physician order dated 4/27/2015 at 1:00 p.m., indicated to give Haldol Decanoate (an antipsychotic medication) 25 mg (milligrams) IM (Intramuscularly Injection) now for delusions.</p> <p>A review of Resident #26's Behavioral/Intervention Monthly Flow Record dated 4/01/2015 indicated Resident #26's behaviors to be pacing, refusing medications, and delusions. Interventions included reassure resident, ensure resident's safety, honor resident's wishes, reapproach (sic) later, and alternate caregivers. The Behavior/Intervention Monthly Flow Record indicated that Resident #26 exhibited pacing behaviors on 4/1, 4/2, 4/7, and 4/9; Refusal of medications on 4/13, 4/14, 4/20, 4/21, and 4/22; no delusional behaviors were documented for the month of April 2015.</p> <p>A review of Resident #26's clinical record indicated in a nursing note dated 4/21/15 at 11:47 p.m., resident refused medication. Interventions of 1:1, back</p>			

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	<p>rub, conversation, left alone and reapproached (sic), offered snack, redirected, reoriented were tried with outcome unchanged. A nurses note dated 4/24/15 at 11:28 a.m., indicated Resident #26 refused medications. Interventions included 1:1 with social worker, assessed for pain, conversation, given food, left alone and reapproached (sic), offered snack, redirected, reoriented, television/radio with outcome unchanged.</p> <p>A social services note dated 4/30/15 indicated the resident had not showered or changed his pants in about 3 weeks. The Director of Nursing was to contact Resident #26's guardian and the doctor to see what the options were as resident had an offensive odor and visibly soiled clothing.</p> <p>The Medication Administration Record (MAR) for April, 2014 indicated Resident #26 had received his scheduled Haldol Decanoate injection on 4/24/2015.</p> <p>A review of April shower sheets received from the Director of Nursing on 6/22/2015 at 8:15 a.m., dated 4/24/15 and 4/14/15 indicated the resident refused a shower on those dates. The record lacked documentation of Resident #26 either receiving or refusing showers on any additional dates in April.</p>			

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	<p>An interview with the Director of Nursing (DON) on 06/19/2015 at 2:58 p.m., indicated that Resident #26 had a very rough couple a weeks and the physician witnessed these behaviors on 4/27/2015. The DON indicated Resident #26 was pacing, refusing care, and incontinent which are Resident #26's normal behaviors. The DON indicated that many staff had tried to talk to Resident #26 into taking a shower and changing his cloths, Resident #26 refused. The DON indicated at this point, on 4/27/2015, Resident #26's condition was a sanitary issue to other residents. The DON indicated that the physician saw these behaviors and ordered the Haldol.</p> <p>An interview with the Medical Director on 06/22/2015 3:36 p.m., indicated he would have to look at the chart in regards to the incident on 4/27/15 but he generally does not resort to an IM injection unless the resident is being delusional and aggressive.</p> <p>A current facility policy provided by the Administrator on 06/23/15 at 3 p.m., titled, "Resident Rights" dated 1997, indicated, "...the resident has the right to be free from any physical or chemical restraints imposed for purpose of</p>			

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F 0332 SS=D Bldg. 00	<p>discipline or convenience and not required to treat the resident's medical symptoms...."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to keep the medication error rate at less than 5% for 2 of 5 residents observed during medication pass. 3 errors were observed during 27 opportunities for errors in medication administration. This resulted in a medication error rate of 11.1%. (Residents #4 and #20)</p> <p>Findings include:</p> <p>1. On 6/16/15 at 10:14 a.m., LPN #6 administered medications to Resident #4, which included Metformin (a medication used to lower blood sugar) ER (extended release) 500 mg (milligrams) take two tablets (1000 mg) by mouth twice daily with meals.</p> <p>The resident's Physicians Orders dated</p>	F 0332	<p>F332 The facility ensures that it is free of medication errors of five percent or greater. Corrective action for residents affected: 1. Resident #4 – unable to correct. 2. Resident #20 – unable to correct. Other residents having the potential to be affected and corrective actions: All residents that receive medication administration have the potential to be affected by this alleged deficient practice. The licensed nurses responsible for medication administration during the observed medication passes are being monitored by the DON / designee to ensure timely medication administration. Measures to ensure practice does not recur:</p>	07/24/2015

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	<p>June 2015, included, but was not limited to: 9/18/13--Metformin ER 500 mg take two tablet (1000 mg) by mouth twice daily with meals at 8 a.m. and 4 p.m.</p> <p>During an interview on 6/16/15 at 10:14 a.m., LPN #6 indicated she was late administering Resident #4's Metformin, which was due at 8 a.m. She indicated the resident should have received his Metformin at mealtime.</p> <p>2. On 6/16/15 at 10:30 a.m., LPN #3 administered medications to Resident #20, which included Olanzapine (an anti-psychotic medication) 5 mg take one tablet by mouth every 12 hours and Amantadine (a medication used to treat Parkinsons disease) 50 mg / 5 ml (milliliters) syrup take five ml (50 mg) by mouth three times daily.</p> <p>The resident's Physicians Orders dated June 2015, included, but were not limited to: 12/3/13--Amantadine 50 mg /5 ml syrup take 5 ml (50 mg) by mouth three times daily at 8 a.m., 12 p.m. and 8 p.m. 3/13/15--Olanzapine 5 mg take 1 tablet by mouth every 12 hours at 8 a.m. and 8 p.m.</p> <p>During an interview on 6/16/15 at 10:40</p>		<p>Licensed nurses and QMAs have been re-educated on facility policy regarding timely medication administration. The DON / designee is responsible for ensuring on-going compliance.</p> <p>This corrective action will be monitored by: The DON / corporate nurse consultant or designee will complete medication pass observations once weekly times 8 weeks, then once per month times 4 months. The observations will be documented, and the DON and ED will be notified immediately if non-compliance is observed. Medication pass observation results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p> <p>Completion Date July 24, 2015</p>		

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F 0353 SS=F Bldg. 00	<p>a.m., LPN #3 indicated this resident's Olanzapine was due to be administered at 8 a.m. She indicated according to the protocol, she had an hour before and after the scheduled medication time to administer a resident's medication. She indicated recently as of 6/15/15, the nurses were told they were not allowed to administer medications to residents anywhere except in their rooms, which was the reason this resident's medications were administered late this morning.</p> <p>A current policy titled "Administering Medications" dated April 2013, provided by the Administrator on 6/19/15 at 4:40 p.m., "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed... In Accordance with Orders: 3. Medications must be administered in accordance with the orders, including any required time frame. Medications Administration Timeframe: 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)...."</p> <p>3.1-25(b)(9)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff</p>			

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	<p>to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to provide enough staff to perform dental care for 2 of 3 residents reviewed for ADL (Activity of Daily Living) care (Residents #34 and #11) and nutritionally at risk resident received a timely meal for 1 of 3 residents reviewed for weight loss. (Resident #18)</p> <p>Findings include:</p> <p>1. During an interview on 6/15/15 at 11:08 a.m., Resident #34 indicated he indicated he did not receive oral care.</p> <p>Resident #34's record was reviewed on</p>	F 0353	<p>F353</p> <p>The facility ensures sufficient nursing staff is available to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>Corrective action for residents affected:</p> <p>1. Resident #34 is being offered oral care daily; care is rendered if resident agrees. CNA Assignment Sheet has been updated to clearly reflect this need. The resident chose to discontinue hospice services effective 7/10/15.</p>	07/24/2015	

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	<p>6/17/15 at 12:50 p.m. Diagnoses included, but were not limited to, chronic pain, contractures on upper/lower extremities, tracheostomy, quadriplegia, and bipolar.</p> <p>A document titled "Shower Schedule" provided by the Administrator on 6/23/15 at 12:10 p.m., indicated the resident's shower schedule was on the evening shift every Tuesday and Friday.</p> <p>The "Shower Report" documents provided dated February 2015 through May 2015, indicated the box in front of "Oral Care provided" was not marked on any of these reports for these months. No "Shower Report" documents were provided for the month of June 2015, by the end of the exit conference on 6/24/15 at 7:15 p.m.</p> <p>The following observations were made on these dates and times: On 6/17/15 at 12:34 p.m., the resident was observed laying in his bed with white debris surrounding his gumlines around his top and bottom teeth. He had contracted bilateral hands and arms. There was no toothbrush or toothpaste observed in the resident's room at that time. He indicated, at that time he did not have a toothbrush or toothpaste. He indicated at that time, he could hold a</p>		<p>2. Resident #11 is receiving oral care daily. CNA Assignment Sheet has been updated to clearly reflect this need. The DON spoke the family member of Resident #11 who verified she spoke with a surveyor; however, she stated that she did not inform them that the facility was not providing oral care. The resident is receiving routine dental care per a private dentist's recommendation.</p> <p>3. Resident #18 was weighed for on 6/24/15 and a weight of 235 was obtained. Weights were continued for three consecutive days; weight recorded on 6/26/15 at 234. The DON consulted with the facility RD and the medical director regarding the resident's weight. Weekly weights were ordered and are being completed per order. The care plan has been updated.</p> <p>4. Aggressive staff recruitment efforts are in process for housekeeping and nursing staff. Recruitment efforts are also in place for a CNA whose primary responsibility will be restorative nursing duties. This will add an additional CNA onto the day shift with some overlap onto the evening shift to assist with showers and meals. The ED was not aware the surveyor did not receive the schedule as worked for 6/18/15. The ED had provided copies of the daily staffing sheets for hours worked from 6/01/15 through 6/22/15. There was no</p>		

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	<p>toothbrush and brush his teeth, if the staff prepared it and handed it to him. He indicated he did not ask the staff to brush his teeth and the staff did not ask him if he wanted to brush his teeth.</p> <p>On 6/18/15 at 8:51 a.m., the resident was observed with white debris surrounding his gumlines around his top and bottom teeth.</p> <p>During an interview on 6/19/15 at 9:43 a.m., CNA #9 indicated the resident did not have a toothbrush or toothpaste in his drawer at that time.</p> <p>On 6/19/15 at 10:08 a.m., the Director of Nursing (DON) indicated the "Oral Care provided" box on the "Shower Report" would be checked if the oral care had been provided. She indicated if the box was empty, that indicated the oral care had not been provided.</p> <p>On 6/19/15 at 11:04 a.m., there were no pink oral swabs, toothbrush or toothpaste observed in the resident's room at that time. Resident #34 indicated, at that time he did not get his teeth brushed or swabbed by the facility staff, but he would like to have his teeth swabbed with the pink oral swabs and asked if there was any way if he could get some swabs because he felt he could use the</p>		<p>further mention of any missing schedule.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. Aggressive staff recruitment efforts are in process for housekeeping and nursing staff. Recruitment efforts are also in place for a CNA whose primary responsibility will be restorative nursing duties. This will add an additional CNA onto the day shift with some overlap onto the evening shift to assist with showers and meals. Laundry par levels have been reviewed and additional linens ordered to ensure adequate supplies are available at all times.</p> <p>Measures to ensure practice does not recur:</p> <p>Nursing staff has been re-educated on the importance of providing assistance with oral care for residents who are unable to complete this task independently. Licensed nurses will be responsible for monitoring the oral hygiene of residents during each tour of duty. If poor oral hygiene is observed, the licensed nurse will immediately request the assigned CNA to offer assistance with oral care. If a resident repeatedly refuses oral care, the CNA will inform his/her licensed nurse supervisor. The nurse will document in the nursing notes and on the 24-hour</p>				

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	<p>swabs easier to brush his teeth than a toothbrush.</p> <p>On 6/19/15 at 11:58 a.m., the DON looked for pink oral swabs, a toothbrush and toothpaste in the resident's nightstand drawers (6 drawers total). There were no pink oral swabs, toothbrushes or toothpaste observed, at that time in any of the drawers. The resident had white debris surrounding his gumlines around his top and bottom teeth. At that time, the DON indicated the resident did not have oral swabs, toothbrush or toothpaste present in his room. She indicated she did not know he had not had oral care done, but she would get some oral swabs.</p> <p>2. On 6/17/15 at 9:21 a.m., the record review for Resident #11 was completed. Diagnoses included, but were not limited to dementia and high blood pressure.</p> <p>On 6/15/15 at 1:56 p.m., the residen's mouth contained pink debris between her teeth.</p> <p>On 6/16/15 at 2:22 p.m., the family member indicated they had been taking the resident to the dentist every 3 months as feel that is what is best for her due to the oral care was not getting done.</p> <p>On 6/17/15 9:36 a.m., the resident was</p>		<p>report. The DON will be responsible for reviewing 24-hour reports daily Monday through Friday, and for bringing these reports to the morning meeting for further review and discussion. The ED, DON, and SSD will continue to meet with therapy staff once monthly to review residents currently receiving rehabilitation services, and to discuss residents with status changes that need to be screened. Recruitment efforts are in place for a CNA whose primary responsibility will be restorative nursing duties. The restorative nursing program has been initiated. The DON / designee will be responsible for ensuring that residents who require restorative nursing services are receiving services as planned.</p> <p>This corrective action will be monitored by: The ED and DON are responsible for monitoring adequate staff every shift, and for acting upon any staff shortage. Staffing numbers for all departments are discussed during morning meeting. There is documentation available of every morning meeting Monday through Friday. The ED will continue to discuss any staffing during the monthly QA Committee meetings and action plans developed to ensure adequate staff. Sufficient staff to meet resident needs will be monitored on-going. Completion Date</p>	

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	<p>observed to have white debris on the bottom teeth.</p> <p>On 6/17/15 at 3:30 p.m., the resident was observed sitting in the hallway with a white debris observed between her bottom teeth and an odor to her breath.</p> <p>On 6/18/15 at 2:34 p.m., the resident was observed with white debris in her bottom teeth on the right side.</p> <p>The shower schedule indicated on Tuesday and Friday in the evenings are the day that Resident #11 is scheduled to receive showers. The shower sheets dated for 6/2/15, 6/5/15, 6/9/15 and 6/16/15, had no indication of refusal of oral care and the box marked oral care completed was not checked.</p> <p>On on 6/19/15 at 10:08 a.m., the Director of Nursing indicated the oral care would be on the shower sheets. She indicated the box would be checked if the oral care had been done, and if the box was empty that would mean it had not been done.</p> <p>3. Resident #18's record was reviewed on 6/17/15 at 10:00 a.m. Diagnoses included, but were not limited to, aggressive behavior, vascular dementia, legally blind, impulse control disorder and expressive aphasia.</p>		July 24, 2015				

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	<p>On 6/18/15 at 8:58 a.m., the resident was laying in bed and had not received his room tray.</p> <p>During an interview on 6/18/15 at 8:59 a.m., the Director of Nursing (DON) indicated if he has his head covered up that meant to leave him alone and he probably had refused to eat.</p> <p>During an interview on 6/18/15 at 9:01 a.m., LPN #3 indicated the CNA's were the ones who passed the breakfast trays and to ask one of them who passed his breakfast tray.</p> <p>During an interview on 6/18/15 at 9:03 a.m., CNA #10 indicated she did not pass his breakfast tray and she did not know if he refused his tray or not because there was only two CNA's, so they both had all the residents.</p> <p>During an interview on 6/18/15 at 9:04 a.m., Cook #8 indicated she did not know he had not come to the dining room for breakfast and needed a room tray, so she did not fix him one.</p> <p>On 6/18/15 at 9:13 a.m., the resident's tray was delivered by the DON and she assisted him with his breakfast.</p>			

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	<p>During an interview on 6/18/15 at 9:18 a.m., CNA #9 indicated she did not know the resident was not given a room tray because she was feeding another resident in his room and she did not know there was only two CNA's here to care for the residents. She indicated she thought there was three CNA's here this morning.</p> <p>During an interview on 6/18/15 at 10:00 a.m., CNA #10 indicated there was only 2 CNA's today and there should have been 3 CNA's, so neither of them knew he was not fed his breakfast.</p> <p>4. During an interview on 6/18/15 at 9:23 a.m., with a CNA who wished to remain anonymous, the staff member indicated residents were not getting the care they were supposed to, including turning and repositioning, oral care, and some residents missed their meal trays or they would get fed extra late. because there were not enough CNA's in the building to provide the care. She also indicated there was only one housekeeper on the day shift and she had to do laundry also and there were times there were no laundry.</p> <p>During an interview on 6/18/15 at 11:06 a.m., the Administrator indicated she was providing care to a resident because a CNA had not shown up yet.</p>			

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	<p>The Quality Assurance Meeting Minutes dated 2/23/15, indicated the Administrator discussed her current openings for staffing, which were three openings needed for housekeeping daily.</p> <p>The Quality Assurance Meeting Minutes dated 3/23/15, indicated the Administrator discussed her current openings for staffing, which were she had one part-time position open in housekeeping, one part-time position open in dietary and two full-time and two part-time positions open for CNA's and Nurses.</p> <p>The Quality Assurance Meeting Minutes dated 4/27/15, indicated the Administrator discussed her current openings for staffing, which were two part-time and two-full time positions in housekeeping, one part-time position in dietary and five full-time positions for nurses and three part-time positions for CNA's. She indicated the positions were listed on job sites and Attendance Incentive Programs were available every quarter to line staff only.</p> <p>The as worked schedule from 6/1/15 to 6/22/15 was requested from the Administrator on 6/22/15 at 12:14 p.m. As of the end of the Exit Conference on 6/24/15 at 7:15 p.m., the as worked</p>			

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F 0371 SS=F Bldg. 00	<p>schedule for 6/18/15 was not provided.</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure foods were stored and served under sanitary conditions for 1 of 1 kitchens being observed for proper food sanitation and handling practices. This deficient practice had the potential to affect 32 of 32 resident receiving food from this kitchen.</p> <p>Findings include:</p> <p>The kitchen tour started on 6/15/15 at 7:58 a.m., with Cook #8 in attendance during the tour. On 6/15/15 at 8:10 a.m., the Dietary Supervisor (DS) entered the kitchen and took over the kitchen tour instead of Cook #8.</p> <p>1. On 6/15/15 at 8:00 a.m., a "Steam Table Temperature" log sheet was</p>	F 0371	<p>F371 The facility stores, prepares, distributes, and serves food under sanitary conditions. Corrective action for residents affected: There were no residents identified as affected. 1. Cook #8 received written disciplinary action regarding the need to obtain and record food temperatures at the steam table. The improper temperature recording for the observed meal could be corrected. 2. Cook #8 received written disciplinary action regarding following posted signs and facility policy for safe food handling. 3. New grates have been placed on the double oven stove top, and the ovens, knobs, metal post in front, gas valves, gas line pipe, and griddle have been thoroughly cleaned. 4. The sanitizer dispensing</p>	07/24/2015

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	<p>hanging above the Steam table. There were no temperatures documented for the steam table food items that had been served up for the room trays for breakfast today, which were already delivered to the residents.</p> <p>During an interview on 6/15/15 at 8:12 a.m., Cook #8 indicated the temperature for the meat she served off the steam table to the residents in their room this morning was 194 F (Fahrenheit). She indicated she had documented the meat temperature for today on 6/14/15, because she thought today was the fourteenth.</p> <p>On 6/15/15 at 4:06 p.m., the temperatures for the Steam Table were documented for 6/15/15 for breakfast food items. The DS indicated the Steam Table temperatures, which were documented after the log sheet was copied this morning at 8:30 a.m., was documented by Cook #8 because she took the breakfast temperatures prior to the residents in the dining room being served. She indicated the temperatures in the meat column was the temperature of the eggs, the temperature in the egg column was the temperature of the muffin. She indicated there was no meat food item served for breakfast today.</p>		<p>mechanism on the dish washer was immediately repaired by the Maintenance Supervisor upon notification by the surveyor of the malfunction. The surveyor was informed and verified that the sanitizer strength was retested and at the required level.</p> <p>5. The uncovered, unlabeled, undated foods observed in the cooler were removed and discarded upon discovery.</p> <p>6. The unlabeled and undated foods in the freezer were removed and discarded upon discovery.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. The Dietary Supervisor has received a written disciplinary action related to the kitchen sanitation concerns observed. The ED completed a kitchen sanitation inspection and dietary staff was instructed to clean all observed concerns.</p> <p>Measures to ensure practice does not recur: Facility policy and procedure related to food temperature recording has been reviewed and revised as deemed necessary. Kitchen cleaning schedule has been reviewed and revised to address all cited concerns. Dietary staff have been in-serviced on sanitary food preparation and handling, temperature recording, and</p>	

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	<p>2. On 6/15/15 at 8:05 a.m., the double ovens had a metal shelf above the griddle on top of the double oven on the right side had handwritten sign taped to the shelf, which indicated "DO NOT STORE PANS ON THIS SHELF." A metal pan with a red food item cut into individual squares covered with plastic wrap was sitting on that shelf. Cook #8 was observed on 6/15/15 at 8:08 a.m., removing the metal pan and putting it in a refrigerator in the back of the kitchen. At that time, Cook #8 indicated the food item in that metal pan, which sat on that shelf was a cake she made at 7:15 a.m., today and the cake was not suppose to be on that shelf. She indicated she placed it on that shelf because she was cleaning up the cabinet area where she had made it.</p> <p>3. On 6/15/15 at 8:13 a.m., the double ovens had a stove top on the left side, which had burnt black and brown colored debris stuck on all 6 grates, the top of the stove and the burner covers. The entire inside of the double ovens had brownish/black colored debris burnt onto the inside of the oven, including the shelves, the bottom of the oven and the inside of the door. The left face covering for the front of the stove top, which had the gas knobs on it had brown colored debris on it. The right face covering for the griddle above the right double oven</p>		<p>monitoring of the dish machine function. This corrective action will be monitored by: The ED will document an inspection of the kitchen once per week x 3 months. The ED will meet with the dietary staff on duty and the DS and instruct on immediate correction of concerns. The consultant RD will continue to complete a kitchen sanitation inspection during monthly visits. Kitchen sanitation inspection results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>	

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	<p>was off. There were gray colored fluffy balls surrounding the metal 3 metal posts in front and open flames could be seen in the back of the griddle.</p> <p>During an interview on 6/15/15 at 8:14 a.m., DS indicated the stove top was deep cleaned twice a month and wiped down everyday when the kitchen staff was through using it at the end of the day. She indicated when the kitchen staff deep cleaned the double ovens and the stove top, they used a chisel to get the burnt on debris off. The DS indicated the face covering off the front of the griddle had been off ever since she had been employed at the facility and that had been almost a year. She indicated she had never tried to order a front to replace the missing one since she had been the Supervisor.</p> <p>On 6/23/15 at 10:30 a.m., the Maintenance Supervisor indicated no facing needed to go on the front of the griddle above the right sided double oven. He indicated the front of the griddle was open to feed oxygen to the flames and that was how the griddle heated up to cook the food. He indicated he had taken a duster to the kitchen on 6/15/15, and cleaned around the valves of the gas pipe line. He indicated there was a large amount of dust around the valves</p>			

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	<p>that needed to be cleaned off that day. He indicated he had told the DS that she needed to get a duster and add the valves to her daily cleaning list to prevent the dust from building up on the gas valves.</p> <p>4. On 6/15/15 at 8:30 a.m., the dishwasher temperature had not been documented on the "Dish machine Temperature Log" for 6/15/15. The Bleach sanitizer concentration had not been documented on the "Bleach Sanitizer Concentration Log" for 6/15/15.</p> <p>On 6/15/15 at 8:44 p.m., the low temperature dishwasher was observed to be tested. The temperatures and sanitizer strength were as followed: Wash cycle-100 F-the DS indicated at that time, it should have been 120 F. Rinse cycle-110 F-the DS indicated at that time, it should have been 125 F. Bleach Sanitizer-0 ppm-the DS indicated at that time, it should have been 50 ppm (parts per million).</p> <p>On 6/15/15 at 8:46 a.m., the low temperature dishwasher was observed to be tested. The temperatures as sanitizer strength were as followed: Wash cycle-110 F-the DS indicated at that time, it should have been 120 F. Rinse cycle-110 F-the DS indicated at that time, it should have been 120 F.</p>			

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	<p>Bleach Sanitizer-0 ppm-the DS indicated at that time, it should have been 50 ppm.</p> <p>A current "Jackson Conserver XL" dishwasher manual undated, provided by the Maintenance Supervisor on 6/15/15 at 3:12 p.m., indicated "...Water Requirements:.. Wash Operating Temperatures: Minimum-120F Recommended-140 F Rinse Temperatures: Minimum-120 F Recommended-140 F. Performance Capabilities:...Minimum chlorine Required (PPM)-50...."</p> <p>During an interview on 6/15/15 at 12:15 p.m., the DS indicated the Maintenance Supervisor had worked on the dishwasher and it was fixed now. She was observed to test the low temperature dishwasher temperatures and sanitizer strength and they were as follows: Wash cycle-118 F- the DS indicated it should have been 120 F. Rinse cycle-126F-the DS indicated it should have been 120 F. Sanitizer-0 mm-the DS indicated it should have been 50 ppm.</p> <p>During an interview at that time, the Maintenance Supervisor indicated he did not know where the dishwasher manual was. The DS indicated she did not know where the dishwasher manual was.</p>			

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	<p>On 6/15/15 at 2:20 p.m., the Maintenance Supervisor indicated the dishwasher was a low temperature dishwasher, but he did not know where the chemical were to be checked at. He indicated he would copy that part of the manual off.</p> <p>On 6/15/15 at 3:13 p.m., the Maintenance Supervisor indicated he did not service the dishwasher, but he will fix little things that broke on the dishwasher. He indicated the area the DS was checking with the chemical strip was considered the drain tub and it had dirty water, which had drained dirty water from the dishwasher after it had washed the dishes. He indicated the DS indicated it used to have purple water, but now it did not</p> <p>The DS indicated at that time, the dietary staff had been checking the dishwasher Sanitizer water with bleach and Quat strips. She indicated (Name of Company) services the dishwasher every six months or when something needs fixed. She indicated the Registered Dietician (RD) would do her checks when she visited also. She indicated the last time the RD visited was on 6/2/15, and the dishwasher temperatures were Wash cycle-112 F, Wash cycle-118 F and Wash cycle-120 F.</p>			

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	<p>She indicated the staff always had to test the dishwasher three times before it got up to the correct temperature.</p> <p>5. On 6/15/15 at 8:52 a.m., the cooler had the following items, which were identified by the DS: Six glasses total of honey thickened water, cranberry and milk liquids and nectar thickened orange juice, water and milk liquids on a tray, which was used for breakfast, but was not covered, dated or labeled before placed in the cooler.</p> <p>Rectangular sheet pan full of garlic bread, which was not covered, dated or labeled before it was placed in the cooler.</p> <p>During an interview at that time, the DS indicated the liquids and the garlic bread should have been covered, dated and labeled before being placed in the cooler.</p> <p>6. On 6/15/15 at 8:58 a.m., the freezer had 15 sticks and 7 pieces of garlic bread identified by the DS, which was not labeled or dated in a bag. The DS indicated at that time, the Garlic bread should have been labeled and dated after it was opened.</p> <p>A current policy dated March 2010, titled "Dishwashing Machine Use" provided by the Administrator on 6/19/15 at 4:40</p>			

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F 0431 SS=D	<p>p.m., indicated "Policy Statement: Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. Policy Interpretation and Implementation:...4. Dishwashing machine chemical sanitizer concentrations and contact time will be as follows: Type of Solution-Chlorine Minimum Concentration-50-100 ppm Contact Time-10 seconds... 5. A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution (measured as parts-per-million [PPM] or mL/L [milliliters/liters] after filling the dishwashing machine and once a week thereafter. Concentrations will be recorded in a facility approved log. 6. Corrective action will be taken immediately if sanitizer concentrations are too low...9. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or PPM are adjusted."</p> <p>3.1-21(h)(1) 3.1-21(h)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS</p>			

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Bldg. 00	<p>& 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 observation, interview and record review, the facility failed to properly label a medication after an order change for 1 of 1 resident observed for direction change labels (Resident #20)</p>	F 0431	F431 Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include appropriate and cautionary instructions and the	07/24/2015			

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	<p>Findings include:</p> <p>During an observation on 6/16/15 at 10:26 a.m., LPN #3 prepared medications for Resident #20. The nurse placed the medications into a paper cup, which included Divalproex Sodium (a medication for seizures) 125 mg (milligrams) two capsules (250 mg). During this observation, the medication card provided from the pharmacy contained the following directions "Divalproex Sodium 125 mg Take 2 capsules (250 mg) by mouth three times daily."</p> <p>A reconciliation of the current physician orders dated June 2015, indicated "Divalproex Sodium 125 mg Take 2 capsules (250 mg) by mouth twice daily." The medication card lacked a "change" of order label to alert the nurse.</p> <p>During an interview on 6/16/15 at 2:30 p.m., LPN #3 indicated the resident's Divalproex Sodium was ordered twice a day, not three times a day as the medication card indicated. The nurse indicated she should have placed a green and white "change" of order label on the medication card to indicate there was a new order change for that medication.</p> <p>A current policy titled "Labeling of</p>		<p>expirations date when applicable.</p> <p>Corrective action for residents affected: The medication card for Resident #2 had an alert label attached indicating there was an order change. Other residents having the potential to be affected and corrective actions: All residents with medication order changes have the potential to be affected by this alleged deficient practice. All medication order changes in the past thirty days have been compared to the current supply of medication cards for each applicable resident, and alert labels attached as indicated. Measures to ensure practice does not recur: Licensed nurses and QMAs have been in-serviced on appropriate card labeling when medication order changes in frequency are received before the current inventory of that medication is depleted. This corrective action will be monitored by: A QA tool will be utilized by the DON / designee to complete medication cart audits once weekly times 8 weeks, then once per month times 4 months. The observations will be documented, and immediately corrected if non-compliance is observed. Audit results will also be presented during the monthly QA</p>				

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F 0441 SS=E Bldg. 00	<p>Medication Containers" dated April 2007, provided by the Administrator on 6/19/15 at 4:40 p.m., indicated "Policy Statement: All medication maintained in the facility shall be properly labeled in accordance with current state and federal regulations. Policy Interpretation and Implementation:... Returning Improperly Labeled Packages: 2. Any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy... Unit Dose Labeling Requirements:... 5. Labels for each single unit dose package shall include all necessary information, such as:.. i. Directions for use... Altering Labels: 7. Only the dispensing pharmacy can label or alter the label on a medication container or package... Notifying Pharmacy of Changes: 9. The nursing staff must inform the pharmacy of any changes in physician orders for a medication."</p> <p>3.1-25(k)(5)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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>Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>	

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	<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. Based on observation, interview and record review, the facility failed to ensure handwashing was performed between blood glucose testing for 2 of 2 residents being observed for blood glucose testing (Residents #2 and #12) and between medication administration for 1 of 5 residents being observed for medication administration. (Resident #2)</p>	F 0441	<p>F441 The facility has established 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. Corrective action for residents affected:</p>	07/24/2015

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	<p>Findings include:</p> <p>1. a. On 6/17/15 at 4:34 p.m., RN #4 was observed donning clean gloves, then she performed blood glucose testing on Resident #2, she removed her gloves, removed the strip in the accucheck machine grabbing the strip at the end away from the blood, threw the strip in the biohazard box on the medication cart and threw away her used gloves on her medication cart.</p> <p>b. On 6/17/15 at 4:41 p.m., RN #4 was observed donning clean gloves, then she prepared Resident #2's sliding scale insulin dosage of Novolog 100 unit/ml (milliliters) 4 units, then removed her gloves. She entered the resident's room, donned clean gloves, administered the Novolog insulin dose to the resident, she threw the used syringe away in the biohazard box on the medication cart, removed her used gloves and threw them away in the trash on the medication cart.</p> <p>2. On 6/17/15 at 4:45 p.m., RN #4 was observed donning clean gloves, performed Resident #12's blood glucose testing, removed her used gloves, she removed the strip in the accucheck machine grabbing the strip at the end away from the blood, threw the strip in</p>		<p>RN #4 has been given a Teachable Moment regarding the need to decontaminate hands through proper handwashing before donning and after doffing gloves. Resident #2 has exhibited no apparent adverse effect from the observed practice during the survey.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. Staff who provides direct resident contact has received instruction on proper hand decontamination through washing or use of alcohol-based rubs.</p> <p>Measures to ensure practice does not recur: Staff who provided direct resident contact has received instruction on proper hand decontamination through washing or use of alcohol-based rubs. Infection control surveillance rounds have been implemented to ensure facility policy regarding hand decontamination is being followed.</p> <p>This corrective action will be monitored by: A QA audit tool will be utilized once weekly x 2 months, then once monthly x 4 month by the DON or designee to monitor proper hand decontamination during direct resident contact. Audit results will be presented during the monthly QA Committee</p>				

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	<p>the biohazard box on the medication cart and threw away her used gloves on her medication cart.</p> <p>During an interview on 6/17/15 at 4:55 p.m., RN #4 indicated she should have washed her hands before and after the blood glucose testing and medication administration and between residents.</p> <p>A current policy titled "Personal Protective Equipment-Gloves" dated August 2009, provided by the Administrator on 6/19/15 at 4:40 p.m., indicated "Policy Statement: Gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin. Policy Interpretation and Implementation: Using Gloves: 1. All employes must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin... Handwashing: 8. Wash your hands after removing gloves...."</p> <p>A current policy titled "Handwashing/Hand Hygiene" dated April 2012, provided by the Administrator on 6/19/15 at 4:40 p.m., indicated "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections... Policy Interpretation and</p>		<p>meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>		

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	<p>Implementation:... Purpose of Handwashing/Hand Hygiene: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors... When to Wash Hands: 5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:... c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); d. Before and after performing any invasive procedure (e.g; fingerstick blood sampling)... u. After removing gloves or aprons... When to Use Alcohol-Based Hand Rub: 6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents... c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications... j. After removing gloves... Removing PPE: 7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. Use of Gloves: 8. The use of gloves does not replace handwashing/hand hygiene...."</p>			
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F 0465 SS=F Bldg. 00	<p>A current policy titled "Point of Care Testing-Glucometer Policy" undated, provided by the Director of Nursing on 6/22/15 at 6:15 a.m., indicated "Purpose: To ensure that the residents requiring blood glucose monitoring via point of care testing are being tested in a safe and accurate manner as indicated by the manufacturer's guidelines and recommendations. Procedures... 2. Disinfect hands...."</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to provide a sanitary and comfortable environment for 30 of 30 residents residing in the facility.</p> <p>Findings include:</p> <p>1. On 6/15/15 at 11:23 a.m., and 6/16/15 at 2:25 p.m., the bathroom shared by rooms 5 and rooms 6 had brown colored debris in both corners of the shower and along the base of the walls, standing water by the drain, peeling paint on sink</p>	F 0465	<p>F465 The facility provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Corrective action for residents affected: No residents were cited as affected. 1. The brown colored debris was removed from the corners and base of walls in the shared bathroom between rooms 5 and 6. The sink cabinet was removed and a wall mounted sink installed. The toilet was replaced. The floor</p>	07/24/2015

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	<p>cabinet, a dark brown stain around front base of toilet, missing tile on left side of sink, and dust in and around ceiling exhaust fan.</p> <p>2. Environmental observations made on 06/16/2015 at 2:24 p.m., and 6/19/15 at 9:35 a.m., indicated the following:</p> <p>a. Multiple pieces of popcorn on floor in lounge near a white desk.</p> <p>b. The base board next to soiled linen chute had a thick layer of dust on it.</p> <p>c. A brown substance on the floor in front of large window next to the main entrance, 1 dead fly on window sill, brown streaks of a dried liquid on the wall next to the large window.</p> <p>d. The base board under the resident rights sign had a layer of dust and the baseboard on wall titled Employee Hall of Fame had a layer of dust.</p> <p>3. Environmental observations made on 6/17/15 at 11:01 a.m., and 6/19/15 at 9:35 a.m., indicated the following:</p> <p>a. Baseboard near exit to driveway and room 6 had a layer of dust with two medication cups, dirt and a scrap of paper between the cupboard and the wall.</p>		<p>has been placed. The wall section where tile were missing has been repaired. The ceiling exhaust fan has been thoroughly cleaned and dust removed.</p> <p>2a.The floor in the lounge has been swept and popcorn removed.</p> <p>2b.The base board next to the soiled linen chute was thoroughly cleaned and dust removed.</p> <p>2c.The floor in front of the large window next to the main entrance was cleaned and the brown substance removed. The dead fly was removed during window sill cleaning. The brown streaks of dried liquid were removed during wall cleaning next to the large window at the main entrance.</p> <p>2d. The base boards under the Resident Rights posting and along the wall below the Employee Hall of Fame were thoroughly cleaned and dust removed.</p> <p>3a.The baseboard near the exit to the driveway and room 6 was thoroughly cleaned and dust, dirt, and debris was removed.</p> <p>3b.All baseboards in room 5 were thoroughly cleaned and black dirt removed.</p> <p>3c.All baseboards in the nursing station were thoroughly cleaned and dust removed. The scuff marks on the walls of the nursing station were cleaned and the wall painted.</p> <p>3d.The wall above the baseboard next to the main entrance door was thoroughly cleaned and the</p>		

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	<p>b. Black dirt on the inside baseboard in room 5 left corner of door.</p> <p>c. A layer of dust on baseboard of nursing station, scuff marks on the walls of nurses station.</p> <p>d. A Hershey Kiss paper wrapper stuck to wall above baseboard next to the main entrance door.</p> <p>e. An pencil eraser sized yellow lump of unknown substance on right side of baseboard outside of room 4.</p> <p>f. A black pencil eraser sized substance with hair stuck to wall across from bathroom for room 4.</p> <p>g. A dead bug on baseboard and a spider web with bugs in left corner of second entrance to dining room.</p> <p>h. Large scrapes in paint on dining room wall near restroom.</p> <p>i. Paint chipped and spackled areas visible in restroom located in dining area, sink pulling away from wall.</p> <p>j. Dining room window sills had layer of dust, a large spider web with 4 dead bugs and pollen under window, wall patched</p>		<p>paper wrapper removed.</p> <p>3e.The baseboard outside of room 4 was thoroughly cleaned and the yellow substance removed.</p> <p>3f.The wall across from bathroom for room 4 was thoroughly cleaned and the substance removed.</p> <p>3g.The baseboard and left corner of the second entrance to the dining room were thoroughly cleaned and dead bugs and spider webs removed.</p> <p>3h.The dining room wall near the restroom has been patched and painted.</p> <p>3i.The chipped and spackled areas in the restroom located in the dining room were sanded and painted to match the walls. The bathroom sink has been replaced.</p> <p>3j.The window sills in the dining room were thoroughly cleaned and dust and dead bugs removed. The wall under the dry erase board was patched, painted, and trimmed to match the other dining room walls.</p> <p>3k A protective cover was placed on the door to the linen chute to cover and protect the damaged areas. The wall to the right of the door was repaired and painted.</p> <p>3l.The baseboard directly across from the nursing station was thoroughly cleaned and dust removed.</p> <p>3m.The scrape above the handrail on the right side next to the kitchen entrance was</p>	

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	<p>and paint a different color under dry erase board near kitchen entrance.</p> <p>k. Large scrapes on door labeled soiled linen chute and wall to right of door.</p> <p>l. A sticky substance tic tac sized on baseboard directly across from the nursing station, with a layer of dust on the baseboard.</p> <p>m. A large scrape above the handrail right side next to the kitchen entrance.</p> <p>n. A large chunk of wall 50 cent sized on right side hallway outside room 15.</p> <p>4. On 06/18/2015 at 9:01 a.m. and 6/19/15 at 9:35 a.m., observation was made of the following:</p> <p>a. Remnants of pop corn on floor in lounge area near a white desk.</p> <p>b. A blue chair in room 8 stained with liquid with urine odor.</p> <p>5. On 06/19/2015 at 9:33 a.m., observation was made of the following:</p> <p>a. Popcorn remnants on floor in lounge by white desk.</p> <p>6. A continuous environmental</p>		<p>patched, sanded, and painted.</p> <p>3n.The wall on the right side of the hallway outside room 15 has been patched and painted.</p> <p>4a.The floor in the lounge has been swept and popcorn removed.</p> <p>4b.The family of the resident in room 8 was notified that the stained and odorous chair may not be compliant with facility policy regarding furniture. The family instructed the facility to remove and discard the chair.</p> <p>5a.The floor in the lounge has been swept and popcorn removed.</p> <p>6.The floor near the head of Resident #3's head has been thoroughly cleaned and the food substance removed.</p> <p>7. All resident rooms and bathrooms are scheduled to be cleaned at least once daily with additional cleaning as needed or per resident request.</p> <p>8a. See 3i. regarding sink replacement.</p> <p>8b.Therapy staff, nursing, and maintenance has collaborated to modify the resident's chair and positioning to prevent continued wall marring</p> <p>8c.The facility is cleaned daily.</p> <p>8d.See 3j. regarding wall patched and painted.</p> <p>8e. See 1. Regarding bathroom repairs.</p> <p>8f. See 2c. regarding wall cleaning.</p> <p>8g. A facility-wide cleaning schedule has been reviewed and</p>		

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	<p>observation of Resident #3's room indicated the following:</p> <p>On 06/15/2015 at 11:30 a.m., egg and what brown meat like substance on floor near Resident #3's head of bed. 06/15/2015 at 3:43 p.m., food remained on floor. 06/16/2015 at 9:18 a.m., egg and meat like substance remained on Resident #3's floor. 06/16/2015 at 11:38 a.m., food remained on the floor 06/16/2015 at 2:22 p.m., eggs and meat like substance were not observed on Resident #3's floor.</p> <p>7. On 6/15/15 at 10:22 a.m., Resident #19 indicated the bathrooms were always dirty.</p> <p>On 06/17/2015 at 11:04 a.m., Housekeeper #18 indicated that she cleaned residents' rooms daily. She would ask residents daily, there are a few where they won't let her clean every day.</p> <p>8. On 06/19/2015 at 9:38 a.m., the Maintenance Manager indicated the following:</p> <p>a. The dining room restroom floor was replaced about 3 weeks ago, the sink was not fixed and was going to be replaced</p>		<p>revised.</p> <p>9. See 4b. regarding the stained chair.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. A facility-wide environmental inspection has been completed, and a punch list of all areas in need of deep cleaning, repair, or replacement has been developed. A plan has been developed with anticipated time frames for completion.</p> <p>Measures to ensure practice does not recur: The facility-wide preventive maintenance plan has been reviewed and revised as deemed necessary. The facility-wide cleaning schedule has been reviewed and revised.</p> <p>This corrective action will be monitored by: A QA audit will be utilized once weekly x 8 weeks the once every two weeks x 4 months by the CCO and/or the regional director of facilities maintenance to identify on-going environmental concerns. The ED will be informed of concerns and an action plan developed. Audit results will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement,</p>		

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	<p>just as soon as it can be done.</p> <p>b. All the scrapes on the walls throughout the facility are from one resident's wheelchair. The resident has to push off due to having 1 leg.</p> <p>c. The facility is to be cleaned daily.</p> <p>d. The large patched area in the dining room was due to a vanity being taken away last Friday, he is planning on painting it soon.</p> <p>e. The dark brown stain around the toilet in the bathroom was due to the staff leaving curtain open while providing showers and the water getting around toilet and down the vent.</p> <p>f. The brown substance on the wall near the front entrance is floor striper.</p> <p>g. There is no cleaning schedule for the facility to clean specific areas on specific days.</p> <p>9. On 06/19/2015 at 9:54 a.m., Housekeeper #18 indicated that the stain to the blue chair in room 8 just happened and that the facility was buying a cloth covering to prevent additional staining. Housekeeping indicated that when furniture was stained the procedure was</p>				<p>and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>		

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F 0490 SS=F Bldg. 00	<p>to use a disinfect to clean the furniture.</p> <p>On 06/23/15 at 3 p.m., a current facility policy provided by the Administrator titled, "Resident Rights" dated 1997, indicated, "...The facility must provide 1. A safe, clean, comfortable, and homelike environment...2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior..."</p> <p>3.1-19(f)</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the Administrator failed to ensure follow up of resident abuse allegations with through investigations for 4 of 4 abuse investigations (Resident #4, #19, # and a confidential interview) and failed to ensure agency staff working as CNA's were licensed to do so. (HHA #7)This deficient practice had the potential to affect 30 of 30 residents living in the facility.</p>	F 0490	<p>F490 The facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. We respectfully request the allegations at 1, 2, and 4 be stricken from the Statement of Deficiencies through IDR based upon evidence submitted in Exhibit D. We</p>	07/24/2015			

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	<p>Findings include:</p> <p>1. During a stage 1 confidential interview with a resident on 06/15/15 at 2:17 p.m., the resident indicated the Administrator, Social Services Director (SSD) and Activities Director (AD) had been verbally and physically abusive to her. The resident also indicated she had been sexually abused by a group of " ...black men ..." who had abused her orally and anally. The resident indicated she had been too scared to notify staff of the abuse. The Administrator was notified of the anonymous allegations on 06/15/15 at 2:51 p.m.</p> <p>An Indiana State Department of Health (ISDH) Incident Report Form provided by the Administrator on 06/17/15 at 9:50 a.m., indicated "Initial Report: 06/15/15..Follow-up Report: 06/16/15...Resident Name: Unknown ...Summary of interview with person(s) reporting the incident ...: Survey team arrived 06/15/15 [sic] Survey team reported a resident wishing to stay anonymous stated the Administrator / [sic] the activities director and the social worker [sic] were all three physically and</p>		<p>believe the administrator reported, investigated, and followed up on allegations of abuse upon full disclosure by the survey team.</p> <p>Corrective action for residents affected:</p> <p>1. Confidential resident: Upon notification by surveyor of alleged physical and verbal abuse per confidential resident, the ED immediately contacted the corporate CEO. The CEO instructed that the ED, SSD, and AD be confined to the basement area that does not house residents receiving certified services until she arrived to begin investigation. The CEO arrived on 6/16/15 and conducted interviews with 5 residents and 2 staff regarding any instances of observed practices that could constitute physical or verbal abuse. All interviews were negative for indicators of abuse by staff to residents. As stated in the survey citation, the ED submitted the report of alleged abuse to the ISDH on 6/15/15 after notification per surveyor. The resident's allegation of sexual abuse was not reported on 6/15/15 along with the afore-mentioned abuse because the surveyor did not elaborate this concern per the confidential interview with the resident. Instead, she asked the ED whether the ED knew anything about "black men". The surveyor</p>				

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	<p>verbally abusive to them. I was then notified. I asked how I was to investigate abuse of an anonymous resident (via conference call). I asked surveyor who stated she needed to ask her supervisor. Surveyor returned to room and instructed me to interview random staff. I arrived to building at 9 am 6/16/15. I interviewed 5 residents and two staff. No allegations of abuse of any type reported by any resident. No witness of abuse by staff ...Conclusion: allegation of abuse unsubstantiated based on interview w/ (with) 5 residents and 2 staff claiming no physical or verbal abuse " Incident report formed was signed by the CEO [Chief Executive Officer]. The sexual abuse allegation was not included as investigated on the Incident Report Form. An ISDH Incident Report Form provided by the Administrator on 06/19/15 at 3:16 p.m., indicated, "Initial Report: 06/17/2015. Follow-up Report: 06/19/2015...Resident Name ...Brief Description of Incident: On 06/15/2015 Surveyor interviewed [resident identified] and returned to the Executive Director stating that the resident had allegations against black men</p>		<p>supervisor met with the ED on 6/17/15 and asked whether anything about sexual abuse regarding black men had been reported to ISDH. The ED asked what the supervisor was talking about. The supervisor stated that the surveyor team had informed her of an allegation of sexual abuse by the confidential resident. The ED informed the supervisor that was not correct. She further informed the supervisor she had requested a written list of concerns from the survey team on 6/16/15 because they had verbalized an extensive amount of concerns on the first day of the survey [6/15/15], and she wanted to be sure she had addressed all concerns. The survey team leader had responded that they were not allowed to provide a list in writing. The ED stated to the supervisor she wished to meet with the team to discuss the fact that she had not been provided any information about sexual abuse by black men toward a resident. She showed the survey team the note she made on her note pad while speaking with the surveyor on 6/15/15 that had the words "black men" written below the notes about the allegation of physical and verbal abuse. The surveyor supervisor informed the ED on 6/17/15 that the concerns could be provided in writing, and she proceeded to instruct the team to provide this. Upon</p>	

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	<p>...Immediate Action: When [resident identified] by surveyor on 06/17/15, Executive Director immediately interviewed [resident identified]. The question was asked, 'Has [sic] a male or any black men entered your room uninvited?' She replied, 'Yes but I didn't know them. There were seven of them.'...Resident indicated that 'You and the staff all know about it. I didn't know the state would tell you'...' The confidential resident was not identified to the Administrator by the survey staff. On 6/17/15 at 12:45 p.m., the Administrator indicated the sexual abuse allegation had not been reported with the physical and verbal allegations. The Administrator indicated the words "black men" had been written on her desk calendar but nothing had been written after those words and she had not followed up. On 6/22/15 at 8:10 a.m., the Administrator provided A Resident Abuse Investigation Report Form which indicated " [Resident identified] ... Additional Comments: Surveyor was reporting abuse on 3 department heads for verbal and physical abuse and when</p>		<p>receiving the additional information of the sexual abuse allegation per the confidential interview, the ED immediately reported to ISDH and initiated the investigation per facility policy. The survey citation validates that the team was provided a copy of the ISDH report dated 6/17/15. Local law enforcement was notified on 6/19/15 and was involved in the investigation. The follow-up report was submitted on 6/19/15 with no substantiation of the allegation. 2. Resident #4 – The survey citation states the ED was informed of an allegation regarding sexual abuse verbalized by this resident during surveyor interview on 6/15/15. That is not a factual statement. The ED was asked by the team leader on 6/15/15 whether she was aware of any "sexual concerns" in the building. The ED responded she was not aware of any sexual concerns. The team leader ended the conversation by leaving the ED office. The ED was first informed that this was an allegation on 6/17/15 when the surveyor supervisor stated she (ED) was not following federal guidelines regarding abuse identification, investigation, and reporting. The supervisor was shown the ISDH reportable log maintained by the ED. The supervisor stated to the ED that she had been informed of an allegation of sexual abuse</p>				

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	<p>ED (Executive Director) was taking notes used ink. During conversation ED had to laid [sic] down pen - in pencil beside ink notes on calendar ED wrote "black men." Surveyor did not elaborate. This allegation was reported to state after clarification between surveyor and ED regarding black men " The form indicated the police department was notified of allegation on 06/19/15 at 10:15 a.m.</p> <p>On 6/23/15 at 11:35 a.m., the Administrator indicated the police were not notified of the sexual abuse allegations until 06/19/15. The Administrator indicated the allegation had been reported to ISDH but then "...it clicked..." and realized she needed to call the police department.</p> <p>2. On 6/15/15 at 10:36 a.m., during a stage 1 interview with Resident #4, the resident indicated other residents in the facility have "...requested sex from him..." The resident indicated, "...he told staff and they didn't do anything" Resident #4 indicated he had not been sexually abused. The Administrator was notified of the allegation on 06/15/15 at 2:15 p.m.</p>		<p>verbalized by Resident #4 on 6/15/15. The ED again met with the surveyor team and requested additional information regarding this new allegation per Resident #4. The team leader responded that she had informed the ED that this resident had expressed a concern regarding sexual abuse. The ED stated she would immediately begin an investigation now that she had clarification of the extremely vague question regarding "sexual concerns" as stated above. The survey citation validates that the team was provided a copy of the ISDH report dated 6/17/15. The ED interviewed Resident #4 on 6/17/15 regarding concerns related to sexual abuse. The resident laughed and stated that this happened a long time (over ten years) ago, and the resident who had requested sex from him has since passed away. The ED also contacted the resident's POA who stated "Is he bringing this up again? It isn't true. He doesn't think straight". A follow up report was submitted to ISDH on 6/19/15 indicating the allegation of current sexual abuse was unsubstantiated.</p> <p>3. Resident #19 – The DON was aware of the resident to resident physical contact that occurred while the residents were preparing to leave for an activity outing on 6/12/15. Resident #19 was immediately checked for injury, and no physical evidence</p>				

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	<p>On 06/17/15 at 12:45 p.m., the Administrator indicated the sexual abuse allegation had not been reported to ISDH or investigated.</p> <p>On 6/18/15 the Administrator provided an ISDH Incident Report Form indicated, "Brief Description of Incident ...Surveyor interview resident who indicated that he had been sexually abused. He indicated that other residents kept approaching him and wanting sex from him...."</p> <p>On 6/22/15 at 8:10 a.m., a Resident Abuse Investigation Report Form was provided by the Administrator indicated, "...Summary of interview with person(s) reporting the incident ...Surveyor came into Executive Director's office, surveyor asked the ED a question, 'are you aware of any sexual concerns in the facility,' [sic] I replied no. Surveyor left my office...Summary of investigator 's findings:...no surveyor did not say concern/complaint ...now that you are saying it is a concern I will immediately investigate... "</p> <p>3. On 6/15/15 at 10:24 a.m., during a stage 1 interview, Resident #19 indicated another resident struck her on the left shoulder. This incident had occurred on</p>		<p>of injury was found. The physician who oversees the medical care for the male resident perpetrator was contacted and gave an order for the resident to be transferred for psychiatric evaluation and treatment. The DON then secured the safety of Resident #19 by implementing the order to send the perpetrator out. She also prepared a written report of the unusual occurrence as instructed by the ED who was not available to complete the report on 6/12/15. The DON informed the ED on 6/15/15 that she was so busy arranging for the transfer of the perpetrator that she failed to submit the report on 6/12/15. The ED completed a Teachable Moment with the DON regarding the importance of timely reporting and initiating an investigation to ensure resident safety and freedom from abuse.</p> <p>4. Resident #32 - RN #2 was immediately suspended pending investigation. The ED interviewed Resident #32; the resident denied any mistreatment or abusive actions by staff.</p> <p>5. The ED immediately contacted the outside agency who employed HHA #7 and explained that the only documentation available for this employee was home health aide certification. The ED also went to the IPLA site to verify this employee's certification and found only home health aide certification. HHA#7 is no longer allowed to take assignments in</p>				

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	<p>the previous Friday. Resident #19 also indicated the same resident had walked in while she had been in the shower room while she had been showering. Resident #19 indicated she reported both incidents to facility staff.</p> <p>On 6/17/15 at 9:50 a.m., the Administrator provided an ISDH Incident Report Form indicated, "Initial Report: 06/15/2015. Follow-up Report: 06/15/2015...Brief Description of Incident: While awaiting their turns to get on activities bus, residents...arguing about who would sit in front seat... Activities Director then heard [Resident #19] exclaim, 'He hit me.' She turned around and immediately escorted all residents back into the building...residents escorted to their respective rooms...she then reported immediately to DON, Administrator and Social Services Director....[resident name] sent to out to [hospital name]... [Resident #19] glad resident is gone...."</p> <p>On 6/22/15 at 8:10 a.m., the Administrator provided a Resident Abuse Investigative Report Form indicated, "...Date Incident Occurred: 06/12/15. Time: 11:45 AM. Date Incident</p>		<p>this facility.</p> <p>6. The ED informed the survey team that she had attempted to contact the DON who left without notice on 4/24/15 when the binder containing wound documentation was discovered missing. The former DON did not respond to the phone calls or text messages from the ED. The surveyor queried whether police had been notified of missing documentation. The ED had no substantiated evidence the former DON removed the wound documentation from the facility prior to quitting without notice. The surveyors were provided with the current binder containing wound documentation, and were offered the MDS supportive documentation regarding pressure ulcers. The ED was not aware that the survey team identified "other documentation" that was missing as stated in the citation at F490 #6.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. A Teachable Moment regarding professional conduct was completed with RN #2 upon reinstatement of job duties. All current residents, known family members or legal representatives of these residents, and all current employees and agency staff were interviewed regarding any</p>		

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	<p>Reported: 06/15/15...Summary of interview with person(s) reporting the incident...:Activity Director came to ED office, Social Service & DON were present in office. Activity Director stated I [sic] just brought residents back in I heard [Resident #19] say 'He hit me. '....Summary of interview with resident.....viewing notes from DON dated 06/12/15 at 12:05 p.m. - [sic] resident also told her verbal threats made...."</p> <p>On 06/22/15 at 11:54 a.m., the Administrator indicated the facility policy was to call resident to resident abuse in to ISDH as a reportable. The Administrator indicated she had been out of the building when the incident occurred on 06/12/15 and the DON should have reported the incident to ISDH. The Administrator indicated the incident was not reported to ISDH or investigated until 06/15/15.</p> <p>4. During a breakfast observation on 06/15/15 at 8:15 a.m., RN #1 was observed to approach Resident #32 in the dining room. RN #1 was observed to have a small cup in her hand and another small object in her other hand. RN #1</p>		<p>observed staff actions or practices that could constitute abuse or mistreatment toward a resident. All interviews were negative for abuse or mistreatment. All allegations involving abuse or mistreatment since the survey have been reported timely, thoroughly investigated, and acted upon as deemed appropriate in accordance with facility policy, federal regulations, and the ISDH Reportable Incidents Policy and Procedure last revised 01/15/13. The ED has requested all agencies who currently are utilized for staff replacement submit the employee credentials documentation directly to her for review prior to employee assignment in facility. The DON who assumed duties on 4/27/15 was instructed to resume wound documentation. Wound assessments are completed weekly per facility policy, and documentation is available.</p> <p>Measures to ensure practice does not recur: Facility policy regarding abuse identification, investigation, and ISDH / other state agency reporting was reviewed and updated as deemed necessary The ED and DON were in-serviced on facility policy by the corporate compliance officer (CCO). CCO or designee will complete reviews at least once per week of all incidents, accidents, and unusual</p>				

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	<p>was observed to state to Resident #32 in a harsh tone, "I'm not dealing with this right now ..." while waving her hand in the air. RN #1 was then observed to walk away from the resident. The Administrator was informed of the event after it occurred.</p> <p>On 6/17/15 at 12:45 p.m., the Administrator indicated the incident had not been reported to ISDH or investigated. The Administrator indicated the allegation had not investigated because the surveyor had not identified the resident to the administrator.</p> <p>An ISDH Incident Report Form provided by the Administrator on 06/18/15 indicated, "...Incident Date 06/15/2015...Resident identified on 06/17/15 ...Brief Description of Incident: ...surveyor was in facility conducting annual survey and was in dining room when she stated that she witnessed [RN #1] attempting to administer medications to ...a resident in a high backed chair ... [RN #1] raised her voice and threw her hands in the air stating, 'I'm not dealing with this right now' and walked away. The Executive Director asked who RN #1 was talking toSurveyor indicated that</p>		<p>occurrences to ensure ISDH reporting requirements are met, and investigations are completed per facility policy. The CEO will be notified of any non-compliance in this area and will determine appropriate action(s). A Guardian Angel Program has been implemented which requires department heads to visit a group of residents twice weekly to review care received and inspect the resident's environment. Any indicators of potential abuse or mistreatment identified through the program will be immediately reported to the ED and acted upon. The ED will request all participants in the morning meetings to report any observed staff to resident or resident to resident behavior(s) that could constitute abuse daily Monday or Friday. The ED will immediately act upon any concerns reported. All current facility employees and agency staff replacement have been in-serviced on abuse prohibition and reporting in accordance facility policy. The ED / Designee is responsible for ensuring that all required documentation applicable to staff replacement utilized through outside agencies has been received and reviewed prior to staff assignment. Agency staff will not be allowed to assume an assignment until documentation of applicable credentials is available. Department managers have been</p>		

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	<p>she would get back to Executive Director as to the identity of the resident ...</p> <p>"Immediate Action: [RN #1 returned to workfollowing a separate incident ...after being provided the identity of the resident involved in above-stated incident"</p> <p>On 6/22/15 at 8:10 a.m., a Resident Abuse Investigation Report Form provided by the Administrator indicated , "Statement - surveyor conducting observation in dining room when [RN #1] was attempting to administer meds (medications), employee raised voice, threw hand in air 'I'm not dealing with this right now - walked away. [sic] ...only witness was surveyor to ED knowledge...unsubstantiated ..."</p> <p>On 6/24/15 at 2:00 p.m., the Administrator indicated the investigation focused on the residents in high backed wheelchairs because the surveyor indicated Resident #32 observed was in a high back wheelchair. The Administrator indicated she did not attempt to interview or identify other residents who fit the description of the resident because of the high backed wheelchair.</p> <p>On 6/17/15 at 2:45 p.m., a current facility</p>		<p>re-educated on HIPAA standards applicable to their positions, and the prohibition on removing any documents with protected health information from the facility premises. The privacy officer will be notified of any HIPAA breaches, and appropriate actions taken.</p> <p>This corrective action will be monitored by:</p> <p>The corporate nurse consultant will review all minutes from morning meetings and reports of incidents or unusual occurrences during routine visits to ensure any occurrence that meets the ISDH reportable requirements has been appropriately reported and investigated. The CCO will complete weekly reviews of incidents to ensure timely reporting and investigation of applicable unusual occurrences. The CCO will complete weekly reviews of agency staff documentation for appropriate credentials and document results on a QA audit tool. Written results of the Guardian Angel visits will be reviewed by the IDT once weekly on-going. Immediate corrective actions will be implemented if indicators of abuse or mistreatment are identified. Guardian Angel visit and audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations,</p>		

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	<p>policy provided by the Administrator titled "Abuse Policy and Procedure (Including Elder Justice Act)" dated 09/25/12, indicated, "Policy: It is the mission of this facility to provide its residents with a safe and pleasant environment in which to live. The facility will endeavor to prevent, report the mistreatment, neglect or abuse of all residents and the misappropriation of property ...Procedure: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish ...This presumes that instances of abuse of all residents ...cause physical harm, or pain or mental anguish ...Immediately report abuse/suspected abuse to the Charge Nurse. The Charge Nurse is to immediately report abuse to the Administrator, who the Abuse Coordinator, and/or the DON if the Administrator is unreachable ...All staff are required to report (phone, fax, electronic mail, mail) reasonable suspicion of a crime against a resident to the local law enforcement within: a. 2 hours - for Serious Bodily Injury if the events that cause the reasonable</p>		<p>performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015</p>	

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	<p>suspicion result in serous [sic] bodily injury to a resident, the staff member shall report the suspicion not later than 2 hours after forming the suspicion. b. 24 hours - for All Others [sic] suspicions [sic] of crime against a resident if the events that cause the reasonable suspicion do not result in serous [sic] bodily injury to a resident, the staff shall report the suspicion not later than 24 hours after forming the suspicion ...7. The Administrative/designee will be responsible to complete a REPORTABLE UNUSUAL OCCURRENCE [sic] form within 24 hours of occurrence via voicemail and send to the ISDH. 8. The Administrator/designee will investigate the situation and report the results of the investigation to ISDH within five working days of the incident ..."</p> <p>5. The employee documentation for the agency nursing aides was reviewed on 6/22/15.</p> <p>A document indicated that HHA #7 was not a certified nursing aide.</p> <p>On 6/22/15 at 2:35 p.m. the Administrator indicated she was the one responsible for the agency staffing. She</p>			

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F 0495 SS=F Bldg. 00	<p>indicated she took care of the hiring and oversight of the employees.</p> <p>On 6/23/15 at 3:20 p.m., the Administrator indicated that HHA who had worked on 6/13/15 as an aide in the building was not a certified nursing aid. She indicated that she counted on the nursing staffing agency to be ensured the staff they send are certified and have the correct training.</p> <p>6. The Administrator indicated on 6/23/15 at 3:15 p.m., the facility had missing documentation for pressure ulcers as well as other documentation and had not followed up after the prior Director of Nursing had left her position.</p> <p>3.1-13(q)</p> <p>483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as</p>				

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	<p>provided in §§483.150(a) and (b). Based on interview and record review, the facility failed to ensure an agency aid had the proper certification to work as a certified nurse aid. (HHA #7) This deficient practice had the potential to affect 30 of 30 residents living in the facility.</p> <p>Findings include:</p> <p>The employee documentation for the agency nursing aides was reviewed on 6/22/15.</p> <p>A document indicated that HHA #7 was not a certified nursing aide.</p> <p>On 6/22/15 at 2:35 p.m. the Administrator indicated she was the one responsible for the agency staffing. She indicated she took care of the hiring and oversight of the employees.</p> <p>On 6/23/15 at 3:20 p.m. the Administrator indicated HHA #7 who had worked on 6/13/15 was not a certified nursing aid. She indicated that she counted on the nursing staffing agency provided her the certification.</p> <p>3.1-14(b)(2)</p>	F 0495	<p>F495 The facility ensures that any individual who has worked less than 4 months as a nurse aid is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in an approved program; or has been deemed or determined competent.</p> <p>Corrective action for residents affected: No residents were identified as affected. The ED immediately contacted the outside agency who employed HHA #7 and explained that the only documentation available for this employee was home health aide certification. The ED also went to the IPLA site to verify this employee's certification and found only home health aide certification. HHA#7 is no longer allowed to take assignments in this facility.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. The ED has requested all agencies who currently are utilized for staff replacement submit the employee credentials documentation directly to her for review prior to employee assignment in facility. All CNAs hired by the facility since 6/24/15 have verification of</p>	07/24/2015	

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			<p>appropriate credentials in the personnel file.</p> <p>Measures to ensure practice does not recur:</p> <p>The ED / Designee is responsible for ensuring that all required documentation applicable to staff replacement utilized through outside agencies has been received and reviewed prior to staff assignment. Agency staff will not be allowed to assume an assignment until documentation of applicable credentials is available. The ED/ Designee is responsible for verification of appropriate licensure or certification through IPLA for all prospective internal nursing staff personnel.</p> <p>This corrective action will be monitored by:</p> <p>The CCO will complete weekly reviews of agency staff documentation for appropriate credentials and document results on a QA audit tool. Immediate corrective actions will be taken if non-compliance is identified. Audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p> <p>Completion Date July 24, 2015</p>	

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F 0496 SS=F Bldg. 00	<p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on interview and record review, the facility failed to ensure agency staff working in the facility had the necessary certification to work with residents. (HHA #7) This deficient practice had the</p>	F 0496	F496 The facility verifies registration of all Certified Nurse Aides prior to their first scheduled tour of duty. Corrective action for residents affected: No residents were identified as	07/24/2015	

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	<p>potential to affect 30 of 30 residents living in the facility.</p> <p>Findings include:</p> <p>The employee documentation for the agency nursing aides was reviewed on 6/22/15.</p> <p>A document indicated that HHA #7 was not a certified nursing aide.</p> <p>On 6/22/15 at 2:35 p.m. the Administrator indicated she was the one responsible for the agency staffing. She indicated she took care of the hiring and oversight of the employees.</p> <p>On 6/23/15 at 3:20 p.m. the Administrator indicated that HHA who had worked on 6/13/15 was not a certified nursing aid. She indicated that she counted on the nursing staffing agency provide her the certification. She indicated she did not check the registry.</p> <p>3.1-14(f)</p>		<p>affected. The ED immediately contacted the outside agency who employed HHA #7 and explained that the only documentation available for this employee was home health aide certification. The ED also went to the IPLA site to verify this employee's certification and found only home health aide certification. HHA#7 is no longer allowed to take assignments in this facility. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. The ED has requested all agencies who currently are utilized for staff replacement submit the employee credentials documentation directly to her for review prior to employee assignment in facility. All CNAs hired by the facility since 6/24/15 have verification of appropriate credentials in the personnel file. Measures to ensure practice does not recur: The ED / Designee is responsible for ensuring that all required documentation applicable to staff replacement utilized through outside agencies has been received and reviewed prior to staff assignment. Agency staff will not be allowed to assume an assignment until documentation of applicable credentials is available. The ED/ Designee is responsible for verification of appropriate licensure or certification through IPLA for all</p>		

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F 0497 SS=F Bldg. 00	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. Based on interview and record review, the facility failed to ensure that CNA's	F 0497	prospective internal nursing staff personnel. This corrective action will be monitored by: The CCO will complete weekly reviews of agency staff documentation for appropriate credentials and document results on a QA audit tool. Immediate corrective actions will be taken if non-compliance is identified. Audit results will be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date July 24, 2015 F497 The facility completes a	07/24/2015	

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	<p>were having their performance evaluated on an annual basis and inserviced accordingly for 9 of the 9 currently employed CNA's working in the facility. This deficient practice had the potential to affect 30 of 30 residents residing in the facility.</p> <p>Findings include:</p> <p>On 6/24/15 at 4:15 p.m., a request was made for annual CNA performance reviews and any inservices for the CNA's.</p> <p>On 6/25/15 at 9:15 a.m., the Administrator provided documentation of inservicing that had been done in the building. Upon review, there were no annual reviews included in the information provided.</p> <p>On 6/25/2015 at 10:39 a.m. ,the Administrator indicated there were no performance reviews completed in the last year by the Director of Nursing for the 9 CNA's employed by the facility.</p> <p>3.1-14(h)</p>		<p>performance review of every nurse aide at least once every 12 months, and provides at least 12 hours of regular in-service education per year.</p> <p>Corrective action for residents affected: No residents were identified as affected. The employment dates of all current facility CNAs were reviewed, and CNAs who have been employed for eleven months or longer have had annual performance reviews completed.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. The employment dates of all current facility CNAs were reviewed, and CNAs who have been employed for eleven months or longer have had annual performance reviews completed.</p> <p>Measures to ensure practice does not recur: The job description for the Director of Nursing position has been revised to include responsibility for the annual performance reviews of all nursing staff who report directly to her. The DON will be responsible for monitoring the length of employment for each nursing staff employment and completing performance reviews timely. The ED will ensure the DON is aware of this responsibility during orientation of any newly-hired</p>		

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			<p>DON.</p> <p>This corrective action will be monitored by:</p> <p>A QA audit tool will be utilized once per week x 2 months, then once per month x 4 months by the CCO to ensure performance reviews are completed timely on CNAs. Audit results will also be presented during the monthly QA Committee meetings and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p> <p>Completion Date July 24, 2015</p>		