

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00159866, IN00160003, and IN00161014.</p> <p>Complaint IN00159866-Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F314, and F465.</p> <p>Complaint IN00160003-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Complaint IN00161014-Substantiated. Federal/State deficiency related to the allegation is cited at F314.</p> <p>Survey dates: January 5, 6, 7, 8, 9, 12, and 13, 2015.</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Heather Tuttle RN-TC Janet Adams RN Lara Richards RN 1/6-1/9, 1/12-1/13/15 Janelyn Kulik RN</p>	F000000		

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

TITLE

(X6) DATE

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

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F000159 SS=D	<p>1/5-1/6/15</p> <p>Census bed type: SNF/NF: 114 Total: 114</p> <p>Census payor type: Medicare: 16 Medicaid: 95 Other: 3 Total 114</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 15, 2015, by Janelyn Kulik, RN.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In</p>				

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	<p>pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to ensure quarterly statements were sent to the resident's responsible party for 1 of 1 residents reviewed for personal funds. (Resident #27)</p>	F000159	<p>F159 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not</p>	02/09/2015

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F000241 SS=D	<p>Findings include:</p> <p>The list of residents whom the facility managed their personal funds was reviewed on 1/12/15 at 3:00 p.m. Resident #27 was identified as having his personal funds being managed by the facility.</p> <p>Interview with the Business Office Manager on 1/12/15 at 3:54 p.m., indicated statements were sent out quarterly and were given monthly if family or a resident asked. She indicated the facility was rep payee for Resident #27 so they did not send out quarterly statements to the family. She indicated if they ask, she let's them know what the resident's balance was in his account but had no documentation of this.</p> <p>Additional interview with the Business Office Manager on 1/13/15 at 10:00 a.m., indicated that she had not been sending out statements to the responsible party of rep payees.</p> <p>3.1-6(g)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p>		<p><i>constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> 1) Immediate action taken for those residents identified: Personal Funds statement was provided to Resident #27 responsible party. 2) How the facility identified other residents: An audit was completed to identify other residents affected, and statements were provided as identified. 3) Measures put into place/ System changes: An audit will be done quarterly to ensure that quarterly statements are provided to all resident responsible parties. The Executive Director will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: Feb 9, 2015</p>				

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	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each residents' dignity was maintained related to wearing hospital gowns in bed, placing personal care signs in rooms, and not covering foley catheter drainage bags with dignity bags for 3 of 4 residents reviewed for dignity of the 9 residents who met the criteria for dignity. (Residents #B, #C, and #D)</p> <p>Findings include:</p> <p>1. On 1/6/15 at 1:19 p.m., Resident #B did not have his foley catheter drainage bag covered with a dignity bag. Urine was visible in the drainage bag.</p> <p>On 1/8/15 at 1:55 p.m., the resident was propelling himself down the hallway in his wheelchair. The resident's foley catheter drainage bag was hooked to the back of his wheelchair. There was no dignity bag covering the foley drainage bag and urine was visible at this time.</p> <p>Interview with the Interim Director of Nursing on 1/13/15 at 11:30 a.m., indicated the resident's foley catheter drainage bag should have been covered</p>	F000241	<p>F 241 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified:</p> <p>1. Resident 8 Now has a dignity bag covering Foley when up and about.</p> <p>2. Resident C has had sign above room removed and has been provided with clothing to wear.</p> <p>3. Resident D has had sign above bed removed and has been provided with clothing to wear.</p> <p>2) How the facility identified other residents:</p> <p>1. All resident with orders for NPO have been identified and room checked and signs have been removed. The facility has checked all rooms to ensure any posted dignity signs have been</p>	02/09/2015			

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	<p>with a dignity bag.</p> <p>2. On 1/5/15 at 11:22 a.m., Resident #C was observed in his room in bed. The resident was wearing a hospital gown and there was a sign above the head of his bed with a picture of a cup with a line drawn through it with the letters NPO (indicating the resident was to have nothing by mouth).</p> <p>On 1/6/15 at 9:31 a.m., the resident was observed in bed wearing a hospital gown and the NPO sign remained above his bed.</p> <p>On 1/7/15 at 9:17 a.m., 9:35 a.m., 10:45 a.m., and 1:10 p.m., the resident was observed in bed wearing a hospital gown. The NPO sign remained above the head of the resident's bed.</p> <p>On 1/8/15 at 9:00 a.m. and 2:19 p.m., the resident was observed in bed wearing a hospital gown. The NPO sign remained above the head of the resident's bed.</p> <p>On 1/8/15 at 11:00 a.m., no clothes were observed in the resident's closet. Interview with LPN #3 and CNA #1 at the time, indicated the resident had no clothes so he was put in a hospital gown daily. The CNA indicated the resident's family visits often but they have not</p>		<p>removed.</p> <p>2.All residents were met with to identify if clothing was available for them. Responsible parties were notified to request that clothing be brought for residents if able. Residents who did not have responsible party or clothing have had clothing provided by facility.</p> <p>3.The facility identified all residents with a foley catheter and have checked to ensure dignity bags are present in each residents room.</p> <p>3) Measures put into place/ System changes:</p> <p>1.Facility will be utilizing an inventory list upon admission and discharge, and if clothing is not available at time of admission a communication form will be developed to notify Social Services of the need for clothing.</p> <p>2.Dignity bags will be available in linen room for residents with Foley catheters.</p> <p>3.In-services will be present on Social Service communication form and inventory sheet.</p> <p>4.In-service will be presented on Dignity focusing on Foley dignity bags and dressing residents after providing care. If resident prefers hospital when in bed it will be on resident centered care plan.</p> <p>5.In-service has been presented to nursing staff regarding dignity signs .</p> <p>4) How the corrective actions will be monitored: Department Heads</p>				

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	<p>brought him in any clothes.</p> <p>On 1/9/15 at 9:55 a.m., the resident was observed in bed wearing a hospital gown. The NPO sign remained above the head of the resident's bed.</p> <p>Interview with LPN #3 at the time, indicated the NPO signs were put in place by the previous Director of Nursing. The LPN indicated that she would remove the NPO sign above the resident's bed.</p> <p>Interview with the Social Service Director on 1/13/15 at 11:35 a.m., indicated that she was not aware the resident did not have any clothes. She indicated that she tried to contact the resident's family and there was no answer. She indicated that she went down to the laundry and got some items for the resident out of lost and found. She did not know if it was the family's preference for the resident to be in a hospital gown.</p> <p>3. On 1/6/15 at 9:45 a.m., Resident #D was observed in bed dressed in a hospital gown. There was also a sign above the head of the bed with a picture of a cup with a line drawn through it with the letters NPO (indicating the resident was to have nothing by mouth).</p> <p>On 1/7/15 at 9:10 a.m. and 2:40 p.m., the</p>		<p>will make QI rounds at least 5x/week as assigned by Executive Director and report any concerns during morning meeting. Executive Director will be responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months 5) Date of compliance: February 9, 2015</p>		

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	<p>resident was observed in bed wearing a hospital gown. The NPO sign was observed above her bed as well.</p> <p>On 1/8/15 at 8:08 a.m., 10:00 a.m., and 2:33 p.m., the resident was observed in bed wearing a hospital gown. The NPO sign was observed above her bed as well.</p> <p>On 1/12/15 at 10:30 a.m., and 2:36 p.m., the resident was observed in bed dressed in a hospital gown.</p> <p>Interview with LPN #1 on 1/8/15 at 10:00 a.m., indicated the old Director of Nursing put those NPO signs above the beds.</p> <p>The record for Resident #D was reviewed on 1/7/15 at 3:05 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, aphasia, PEG tube, dementia, high blood pressure, congestive heart failure, depressive disorder, stroke, and anemia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/17/14 indicated the resident's cognition was severely impaired. The resident required total dependence on staff for most of her Activities of Daily Living including dressing. The resident was at risk for pressure ulcers.</p>						

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F000278 SS=D	<p>There was no preference assessment completed for the resident to determine if it was the resident's choice for wearing a hospital gown.</p> <p>The current 11/3/14 plan of care plan indicated there was no care plan indicating the resident preferred to be dressed in a hospital gown.</p> <p>Interview with the North Unit Manager on 1/12/15 at 2:36 p.m., indicated the resident should be dressed in a regular clothes unless she does not have any.</p> <p>This Federal Tag relates to Complaint IN00159866</p> <p>3.1-3(t)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the</p>			
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	<p>accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set assessment was accurately coded related to the use of antipsychotic medications for 1 of 1 residents reviewed for pre-admission screening and range of motion for 1 of 3 residents reviewed for range of motion of the 10 who met the criteria for range of motion. (Residents #48 and #86)</p> <p>Findings include:</p> <p>1. The record for Resident #86 was reviewed on 1/12/15 at 9:07 a.m. The resident's diagnoses included, but were not limited to, bipolar disorder and schizoaffective disorder.</p> <p>A Physician's order dated 8/14/14, indicated the resident was to receive</p>	F000278	<p>F278</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1.R#86- MDS with ARD of 11/13/14 was corrected to reflect anti-psychotic use in section N. R#48-MDS with ARD 10/17/14</p>	02/09/2015	

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	<p>Risperdal (an antipsychotic medication) 1 milligram (mg) daily.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/13/14, indicated under Section N Medications, the resident had not received an antipsychotic medication within the past seven days.</p> <p>Interview with the MDS Coordinator on 1/13/15 at 11:29 a.m., indicated the resident's Risperdal was not coded on the Quarterly MDS and it should have been.</p> <p>2. On 1/6/15 at 10:08 a.m., Resident #48 was observed with contractures to both of her hands. Interview with the resident at the time, indicated she had severe rheumatoid arthritis for many years. She indicated her hands had been contracted for some time.</p> <p>The record for Resident #48 was reviewed on 1/7/15 at 11:18 a.m. The resident had just been admitted to the facility on 10/10/14. The resident's diagnoses included, but were not limited to, rheumatoid arthritis, muscle weakness, and muscular wasting and atrophy.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 10/17/14 indicated the resident was alert and oriented. The resident had no physical</p>		<p>was corrected to reflect Range of Motion limitations in section G.</p> <p>2. All current residents with ARD of 12/23/14 and forward receiving Antipsychotics were reviewed to confirm they were marked correctly on most recent OBRA MDS.</p> <p>All current residents with ARD of 12/23/14 and forward were reviewed for accuracy in coding section G with review comparison of the most recent Range of Motion assessment.</p> <p>3. MDS Coordinator was in serviced on correct coding of section N for antipsychotic medications, section G for upper/lower extremities as indicated on Range of motion assessment. MDS Coordinator and/or designee will audit 5 records weekly for accuracy in coding antipsychotics and upper/lower limitations in section G.</p> <p>4. The Executive Director will monitor compliance through review of the inspection forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for 6 months.</p>		

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	<p>impairment to her upper extremities and impairment to both sides for lower extremities.</p> <p>The restorative bed mobility observations dated 10/10/14 indicated the resident had limited range of motion or usage to left and right arms, and left and right legs.</p> <p>The restorative range of motion observation dated 10/17/14 indicated the resident's left and right shoulder, left elbow, left wrist, was severe less than 50% of normal function. The resident's left and right hands were fixed with no mobility.</p> <p>Further review of the restorative range of motion observation indicated the resident had contractures and had the potential for more contractures.</p> <p>Interview with the MDS Coordinator on 1/8/15 at 11:00 a.m., indicated she did not feel the resident had upper extremity impairments that would effect her ADL status or at risk for injury.</p> <p>Interview with the Restorative Nurse on 1/8/15 at 11:00 a.m., indicated the range of motion assessment she completed on 10/17/14 indicated the resident had range of motion limitations and had contractures to her upper extremities.</p>		5) 2/9/15				

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F000280 SS=D	<p>3.1-31(h)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to ensure residents were allowed to participate in their plan of care related to failure to notify the resident the medications ordered by his Physician were not available for administration for 1 of 3 residents reviewed for participation in care planning of the 4 who met the criteria for participation in care planning. (Resident #159)</p> <p>Findings include:</p>	F000280	<p>F 280 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it</p>	02/09/2015			

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	<p>Resident #159 was interviewed on 1/6/15 at 9:36 a.m. The resident indicated the staff have not told him about his plan of care. The resident indicated the staff kept telling him they were waiting on the Doctor and then did not get back to him with any information.</p> <p>The record for Resident #159 was reviewed on 1/7/15 at 2:02 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, end stage renal disease, diabetes mellitus, and peripheral vascular disease.</p> <p>Review of the 12/27/14 Admission/Re-Admit Assessment indicated the resident was alert, verbally appropriate, and orientated to person, place, time, and situation. The assessment also indicated the resident communicated in English.</p> <p>A Quarterly MDS (Minimum Data Set) assessment completed on 12/30/14 at 11:07 a.m. indicated the resident had the ability to understand and to make his self understood. The 1/4/15 Admission MDS assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (14). A score of (14) indicated the resident's cognitive patterns were intact.</p>		<p><i>is required by the provisions of federal and statelaw.</i></p> <p>Immediate actions taken for those residents identified: Resident #159 pharmacy was called about medication not arriving at facility at the time it was brought to nurse manager attention. Medication arrived and resident is receiving medication as ordered Resident has been informed of medication and reason for each.</p> <p>How the facility identified other residents: All residents' physician orders were reviewed and medication carts and medication rooms checked to ensure all medications ordered by physicians are present.</p> <p>Measures put into place/ System changes: A Plan of Care in-Service has been presented with content focusing on resident's participation in their plan of care. Focus also on informing residents that are alert and orientated about their plan of care such as medication and any other pertinent information.</p> <p>How the corrective actions will be monitored: The DON or designee will audit progress notes during clinical meeting at least 5x/week x30 days, then weekly thereafter to ensure residents who are their own responsible party are notified of their plan of care. The results of these audits will be reviewed in Quality Assurance</p>				

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	<p>The 12/2014 Nursing Progress Notes were reviewed. An entry made on 12/27/14 at 1:35 p.m. indicated the resident arrived from another facility. The entry also indicated the resident was alert and orientated and able to make his needs known.</p> <p>The 12/28/2014 Nursing Progress Notes were reviewed. An entry made on 12/28/14 at 6:24 a.m. indicated the staff were waiting for the residents's medications to come from pharmacy. An entry made on 12/28/14 at 3:04 p.m. indicated the resident was alert and verbally responsive. There was no documentation in the 12/28/14 Nursing Progress Notes of the resident being informed about his medications not being available.</p> <p>The 12/29/14 Nursing Progress Notes were reviewed. Entries made on 12/29/14 at 5:43 a.m., 5:44 a.m., and 5:45 a.m. indicated the staff were awaiting for the residents' medications to be delivered from pharmacy. There was no documentation in the 12/29/14 Nursing Progress Notes of the resident being informed about his medications not being available</p> <p>The 1/2015 Nursing Progress Notes were reviewed. There were entries made on</p>		<p>Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: February 9, 2015</p>		

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	<p>1/3/15 at 1:26 p.m., 1:27 p.m., 1:28 p.m., 1:33 p.m., 1:34 p.m. and 1:36 p.m. These entries all indicated the resident's medications were not available. Further entries made on 1/3/15 at 7:06 p.m. 7:07 p.m., 7:08 p.m., and 7:09 p.m. all indicated the resident's medications were not available. There was no documentation of the resident being notified of the unavailability of his medications in the above entries.</p> <p>The 1/4/15 Nursing Progress Notes were reviewed. Entries made at 8:18 a.m. and 12:22 p.m. all indicated the residents medications were not available from pharmacy. There was no documentation of the resident being notified of his medications not being available.</p> <p>When interviewed on 1/8/15 at 9:10 a.m., LPN #10 indicated the resident was alert and orientated, understands, and could make his own decisions.</p> <p>When interviewed on 1/9/15 at 10:35 a.m., the Assistant Social Service indicated the resident was his own responsible party and could be notified of condition or care issues.</p> <p>3.1-35(d)(2)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the Plan of Care were followed as written related to administration of insulin and monitoring blood sugars for 1 of 5 residents reviewed for unnecessary medications.</p> <p>The facility also failed to ensure toileting was provided in a timely manner for a resident with urinary incontinence for 1 of 3 residents reviewed for urinary incontinence of the 3 who met the criteria for urinary incontinence. (Residents #33 and #140)</p> <p>Findings include:</p> <p>1. The record for Resident #140 was reviewed on 1/8/15 at 3:09 p.m. The resident's diagnosis included, but was not limited to, diabetes.</p> <p>A Physician's order dated 12/10/14, indicated the resident was to receive Humulin Regular insulin, inject per sliding scale before meals and at bedtime. The resident was to receive the following dose of insulin based on his blood sugar.</p>	F000282	<p>F 282 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1. Immediate actions taken for those residents identified:</p> <p>1. Resident # 140 resident was assessed for signs and symptoms of hyper or hypo glycemia, and blood sugar was checked with glucometer. No negative outcome.</p> <p>2. Resident #33 was toileted at time it was brought to CNA attention.</p> <p>2. How the facility identified other residents:</p> <p>1. All residents' who had physician orders for sliding scale and blood sugar checks were reviewed.</p> <p>2. Facility has identified all residents with urinary</p>	02/09/2015			

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	<p>150-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units</p> <p>The December 2014 Medication Administration Record (MAR), indicated there was no blood sugar documented for 12/12, 12/13, 12/25, and 12/29/14 at 6:59 a.m. There was no blood sugar documented on 12/17/14 at 8:00 p.m.</p> <p>The December 2014 MAR, indicated the resident's blood sugars were as follows:</p> <p>12/10/14 at 4:00 p.m., blood sugar 155. 12/11/14 at 11:00 a.m., blood sugar 235. 12/11/14 at 4:00 p.m., blood sugar 226. 12/11/14 at 8:00 p.m., blood sugar 187. 12/12/14 at 11:00 a.m., blood sugar 162. 12/14/14 at 6:59 a.m., blood sugar 292. 12/14/14 at 4:00 p.m., blood sugar 191. 12/14/14 at 8:00 p.m., blood sugar 152. 12/15/14 at 6:59 a.m., blood sugar 202. 12/15/14 at 4:00 p.m., blood sugar 277. 12/16/14 at 6:59 a.m., blood sugar 202. 12/17/14 at 6:59 a.m., blood sugar 170. 12/18/14 at 6:59 a.m., blood sugar 331. 12/18/14 at 4:00 p.m., blood sugar 216. 12/18/14 at 8:00 p.m., blood sugar 154. 12/19/14 at 4:00 p.m., blood sugar 158. 12/22/14 at 11:00 a.m., blood sugar 152.</p>		<p>incontinence per MDS assessment.</p> <p>3.Measures put into place/ System changes:</p> <p>1.Glitch in computer program was identified and slidingscales have been re-entered.</p> <p>2.Nurses have been in-serviced if unable to document inMAR section of computer program to document Blood Glucose results and sliding scale dose given in nursing progress notes and notify nursing manager.</p> <p>3.Restorative nurse has reviewed all MDS and identified residents appropriate for bladder assessment and training program and those who are incontinent and are appropriate for a check and change program.</p> <p>4. Nursing staff will be re-educated regarding policy for incontinence/ toileting rounds. 4. How the corrective actions will be monitored</p> <p>1. The Director of Nursing and or Designee will audit medication record of at least 3 residents receiving sliding scale insulin and blood sugar checks weekly to ensure compliance.</p> <p>2.The Director ofNursing or designee will observe at least 5 incontinent residents per week onvaried shifts to ensure incontinence/ toileting rounds are completed timely.</p> <p>3.The results ofthese audits will</p>				

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	<p>12/22/14 at 4:00 p.m., blood sugar 250. 12/23/14 at 4:00 p.m., blood sugar 241. 12/23/14 at 8:00 p.m., blood sugar 178. 12/24/14 at 6:59 a.m., blood sugar 167. 12/25/14 at 8:00 p.m., blood sugar 215. 12/26/14 at 4:00 p.m., blood sugar 186. 12/28/14 at 6:59 a.m., blood sugar 265. 12/28/14 at 4:00 p.m., blood sugar 263. 12/28/14 at 8:00 p.m., blood sugar 205. 12/30/14 at 6:59 a.m., blood sugar 167. 12/31/14 at 6:59 a.m., blood sugar 166.</p> <p>There was no insulin coverage recorded for the above dates. The code entered on the computerized medication sheet was "15", indicating no insulin was required.</p> <p>The January 2015 MAR, indicated there were no blood sugars recorded on 1/1, 1/3, and 1/8/15 at 6:59 a.m.</p> <p>The January 2015 MAR, indicated the resident's blood sugars were as follows:</p> <p>1/2/15 at 6:59 a.m., blood sugar 163. 1/2/15 at 8:00 p.m., blood sugar 272. 1/5/15 at 4:00 p.m., blood sugar 164. 1/5/15 at 8:00 p.m., blood sugar 197. 1/7/15 at 4:00 p.m., blood sugar 186. 1/8/15 at 4:00 p.m., blood sugar 185.</p> <p>Again, there was no insulin coverage recorded for the above dates. The code entered on the computerized medication</p>		<p>be presented at Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: February 9, 2015</p>				

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	<p>sheet was "15", indicating no insulin was required.</p> <p>The plan of care dated 12/10/14, indicated the resident had Diabetes Mellitus. The interventions included, but were not limited to, give diabetes medication as ordered by doctor.</p> <p>Interview with LPN #9 on 1/8/15 at 3:30 p.m., indicated there was a problem with the computer program and the amount of insulin administered could not be documented. She further indicated the amount of insulin given should have been documented in the Nursing progress notes.</p> <p>Interview with the Nurse Consultant on 1/13/15 at 10:00 a.m., indicated there was a glitch in the computer system and it would not show the amount of insulin the resident received.</p> <p>2. On 1/7/15 at 9:29 a.m., 10:40 a.m., 11:05 a.m., 11:31 a.m., and 12:00 p.m., Resident #33 was observed seated in her wheelchair in the dining room on the PCU Unit. The resident remained in the dining room during the above observations without staff checking for incontinence or taking her to the bathroom. The resident did not leave the dining room during the above times.</p>						

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	<p>On 1/7/15 from 12:00 p.m. to 1:03 p.m., the resident was observed eating lunch. She was seated in her wheelchair at a dining room table. During this time, no staff had checked, changed or taken the resident to the toilet.</p> <p>On 1/7/15 at 1:30 p.m., CNA #7 was asked if she had checked for incontinence or changed Resident #33. She indicated she had done that about an hour ago, however when she entered the dining room to get the resident again, she indicated the resident was not in the dining room. The resident was in the dining room. The CNA indicated she did not know who Resident #33 was. Further interview with CNA #7 indicated she had not taken the resident to the bathroom or checked her for incontinence at all since she had been there from the start of her shift which began at 7:00 a.m. CNA #8 and CNA #7 assisted the resident back to her room and placed her on the toilet. At that time, the resident's incontinent brief was removed and it was heavily saturated with urine. The urine was strong and foul smelling. Both CNAs indicated there had been another CNA on the unit earlier to help, however she had left at 12:30 p.m. Both CNAs indicated the resident was a two person assist due to her inability to stand for a long time. CNA #7 and CNA #8 indicated they were</p>			

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	<p>to check for incontinence and/or change the residents brief at least every two hours.</p> <p>The record for Resident #33 was reviewed on 1/7/15 at 10:34 a.m. The resident's diagnoses included, but were not limited to, difficulty walking, abnormal gait, dementia, adult failure to thrive, cognitive deficits, disorder of the kidneys, legal blindness, and hearing loss.</p> <p>The Quarterly MDS assessment dated 11/4/14 indicated the resident was always incontinent of bladder.</p> <p>The care plan dated 10/28/14 indicated the resident was incontinent of bladder related to with/without a pattern of incontinence and would benefit from a scheduled toileting program related to cognitive impairment. The Nursing approaches were to allow ample time for voiding, take assist and cue to go to the bathroom upon rising, before and after meals and at bedtime and as needed.</p> <p>Interview with LPN #2 on 1/7/15 at 1:50 p.m., indicated the resident should have been taken to the bathroom before lunch or at least checked for incontinence.</p> <p>Interview with the PCU Unit Manager</p>						

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F000309 SS=D	<p>1/7/15 at 1:45 p.m., indicated residents were to be checked and or changed every 2 hours</p> <p>3.1-35(g)(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 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure non pressure areas related to an open area of dry skin was assessed and treated for 1 of 2 residents reviewed for non pressure areas. The facility also failed to complete the pre and post dialysis assessments for 1 of 1 residents reviewed for dialysis. (Residents #D and #E)</p> <p>Findings include:</p> <p>1. On 1/7/15 at 2:40 p.m., Resident #D was observed in bed. At that time, CNA #1 and CNA #5 were providing incontinence care. At that time, the resident's pillow which was located under her heels had fresh red blood and dried brown blood noted to the pillow case.</p>	F000309	<p>F 309 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified:</p> <p>1. Resident D An order for treatment of identified area on left heel was received and treatment provided as ordered</p> <p>2. Resident E The pre and post assessment was completed</p>	02/09/2015	

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	<p>CNA #1 was asked to pick up the resident's left heel. There was an open area noted to her left heel. The area was red and surrounded by dry flaky skin. There was no bandage observed on the heel. The resident was not wearing any protective equipment to her heels as they were then propped up back on the pillow. Interview with CNA #1 and CNA #5 at that time, indicated they really did not know if that open area was new or not.</p> <p>On 1/8/15 at 10:00 a.m., LPN #1 was asked to remove the linens from the resident's feet. At that time, there was a moderate amount of dried blood and fresh blood noted on the pillowcase in which the resident's heels were propped up on. The left heel was open and bleeding. The LPN indicated she was unaware the resident had any new open areas to the left heel. At that time, she was informed there were two CNAs yesterday providing incontinence care and they were made aware of the open area to the left heel. LPN #1 indicated neither CNA had informed her of the new open area and she had worked yesterday on the same hall.</p> <p>The record for Resident #D was reviewed on 1/7/15 at 3:05 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, aphasia, PEG</p>		<p>onnext dialysis appointment. How the facility identified otherresidents: 1.A Braden assessment was completed on all residents. Allresidents identified as at risk will have skin assessment completed and anyissues identified will be addressed as needed. 2.Allresidents receiving dialysis have been identified and records reviewed. Measures put into place/ System changes: 1.Nursing staff will be in-serviced regarding procedurefor notification of new skin concerns and obtaining treatment orders. 2.Licensed staff will be in-serviced regarding completionof Pre and Post Dialysis assessments. How the corrective actions will be monitored: 1.DON/designee will audit pre/post dialysisassessment documentation three times a week for 3 months and then weekly for 3months to ensure compliance. 2.DON/ designee will complete a skin assessmenton at least 5 residents at risk for skin breakdown per week to ensure any identifiedskin concerns have been addressed. 3.The results of these audits will be reviewedin Quality Assurance Meeting monthly x3 months, then quarterly x1 for a</p>				

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	<p>tube, dementia, high blood pressure, congestive heart failure, depressive disorder, stroke, and anemia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/17/14 indicated the resident's cognition was severely impaired. The resident required total dependence on staff for most of her Activities of Daily Living. The resident was at risk for pressure ulcers.</p> <p>Review of Physician Orders dated 9/24/14 indicated lac hydrin lotion apply topically one time a day prophylaxis to feet.</p> <p>The skin/feet assessment dated 1/4/15 indicated the resident had a blister to bottom of the right foot which measured 2.5 centimeters (cm) by 2.1 cm.</p> <p>The non pressure ulcer progress report dated 1/6/15 indicated the eschar had come off to the bottom of the right foot and protective barrier was to be applied daily.</p> <p>There was no non pressure ulcer progress report for the open area on the left heel available for review.</p> <p>The current care plan dated 11/13/14 indicated there was no care plan related</p>		<p>totalof 6 months. Date of compliance: February 9, 2015</p>				

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	<p>to non pressure ulcers.</p> <p>Interview with LPN #1 on 1/8/15 at 10:53 a.m., indicated she had called the doctor and got new orders for the left heel. She also indicated there was no current treatment order for the left heel open area.</p> <p>The non pressure ulcer progress report dated 1/8/15 completed at 3:51 p.m., by wound nurse indicated the resident had dry skin to the left lateral heel which measured .3 cm by .5 cm. by .1 cm. The wound bed was 100% red. The surrounding tissue was intact with small amount of serous sanguineous drainage noted.</p> <p>The Physician Order dated 1/8/15 indicated bottom of left foot: cleanse left foot with soap and water, pat dry and apply Bacitracin ointment and mepore daily until healed.</p> <p>Interview with LPN #1 on 1/8/15 at 1:14 p.m., indicated both of the CNAs from the day before should have informed a nurse regarding the new open area to the left heel.</p> <p>2. The record for resident #E was reviewed on 1/8/15 at 9:21 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus,</p>			

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	<p>depressive disorder, glaucoma, anemia, pressure ulcer, anxiety state, and renal dialysis.</p> <p>A Pre Dialysis Data assessment form and a Post Dialysis assessment form were both reviewed. The assessment forms indicated the resident's orientation, vital signs, breath sounds, presence of edema, complaints of pain, shortness of breath, cough, heart rate rhythm, skin, vascular access including presence of thrill, bruit, dressing, drainage from the site were all to be included on the assessment form. Any other symptoms such as bleeding, bruises, nausea, vomiting, unusual itching, falls, abdominal pain, or change in urine amount or appearance were all to be assessed.</p> <p>There was no Pre Dialysis Data assessment completed on 1/5/15. There were no Post Dialysis assessment forms completed on 12/23/14, 12/26/14, and 1/7/15.</p> <p>When interviewed on 1/9/15 at 8:54 a.m., LPN #5 indicated she had taken care of the resident. The LPN indicated the resident was sent out for Dialysis this morning. The LPN indicated the protocol was for the Nurse to complete the Pre Dialysis assessment form on the computer prior to the resident being</p>			

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F000312 SS=D	<p>transferred out for dialysis and then complete a Post Dialysis assessment form at the time the resident returned to the facility.</p> <p>When interviewed on 1/9/15 at 9:02 a.m., the facility Nurse Consultant indicated the Nurses were to complete the Pre and Post Dialysis forms.</p> <p>This Federal tag relates to Complaint IN00160003.</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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to maintain continence for 1 of 3 residents reviewed for urinary incontinence of the 3 residents who met the criteria for urinary incontinence. (Resident #33)</p> <p>Findings include:</p> <p>On 1/7/15 at 9:29 a.m., 10:40 a.m., 11:05</p>	F000312	<p>F 312 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it</p>	02/09/2015

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	<p>a.m., 11:31 a.m., and 12:00 p.m., Resident #33 was observed seated in her wheelchair in the dining room on the PCU Unit. The resident remained in the dining room during the above observations without staff checking for incontinence or taking her to the bathroom. The resident did not leave the dining room during the above times.</p> <p>On 1/7/15 from 12:00 p.m. to 1:03 p.m., the resident was observed eating lunch. She was seated in her wheelchair at a dining room table. During this time, no staff had checked, changed or taken the resident to the toilet.</p> <p>On 1/7/15 at 1:30 p.m., CNA #7 was asked if she had checked for incontinence or changed Resident #33. She indicated she had done that about an hour ago, however when she entered the dining room to get the resident again, she indicated the resident was not in the dining room. The resident was in the dining room. The CNA indicated she did not know who Resident #33 was. Further interview with CNA #7 indicated she had not taken the resident to the bathroom or checked her for incontinence at all since she had been there from the start of her shift which began at 7:00 a.m. CNA #8 and CNA #7 assisted the resident back to her room and placed her on the toilet. At</p>		<p><i>is required by the provisions of federal and statelaw.</i></p> <p>Immediate actions taken for those residents identified: Resident# 33 was toileted at time of observation. Resident has been placed on a checkand change if needed every 2 hours.</p> <p>How the facility identified other residents: Facilityhas identified all residents with urinary incontinence per MDS assessment.</p> <p>Measures put into place/ System changes: Nursing staff will be re-educatedregarding policy for incontinence/ toileting rounds.</p> <p>How the corrective actions will be monitored The Director ofNursing or designee will observe at least 5 incontinent residents per week onvaried shifts to ensure incontinence/ toileting rounds are completed timely. The results of theseaudits will be reviewed in Quality Assurance Meeting monthly x3 months, thenquarterly x1 for a total of 6 months.</p> <p>Date of compliance: February 9, 2015</p>	

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	<p>that time, the resident's incontinent brief was removed and it was heavily saturated with urine. The urine was strong and foul smelling. Both CNAs indicated there had been another CNA on the unit earlier to help, however she had left at 12:30 p.m. Both CNAs indicated the resident was a two person assist due to her inability to stand for a long time. CNA #7 and CNA #8 indicated they were to check for incontinence and/or change the residents brief at least every two hours.</p> <p>The record for Resident #33 was reviewed on 1/7/15 at 10:34 a.m. The resident's diagnoses included, but were not limited to, difficulty walking, abnormal gait, dementia, adult failure to thrive, cognitive deficits, disorder of the kidneys, legal blindness, and hearing loss.</p> <p>The bowel and bladder assessment dated 11/2/14 indicated the resident uses incontinent briefs and was frequently incontinent. The resident needed assist of 1 to 2 to toilet.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated 8/4/14 indicated the resident needed extensive assist with 2 person physical assist for transfers and toilet use. The resident was</p>			

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	<p>frequently incontinent of bladder.</p> <p>The Quarterly MDS assessment dated 11/4/14 indicated the resident was always incontinent of bladder.</p> <p>Interview with LPN #2 on 1/7/15 at 10:53 a.m., indicated the resident had a big decline with her Activities of Daily Living and mental status over the last five months.</p> <p>The care plan dated 10/28/14 indicated the resident was incontinent of bladder related to with/without a pattern of incontinence and would benefit from a scheduled toileting program related to cognitive impairment. The Nursing approaches were to allow ample time for voiding, take assist and cue to go to the bathroom upon rising, before and after meals and at bedtime and as needed.</p> <p>The CNA communication sheet indicated the resident was a 1 to 2 assist, used the toilet, and wore briefs.</p> <p>Interview with LPN #2 on 1/7/14 at 1:50 p.m., indicated the resident should have been taken to the bathroom before lunch or at least checked for incontinence.</p> <p>Interview with the PCU Unit Manager 1/7/14 at 1:45 p.m., indicated residents</p>			
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F000314 SS=D	<p>were to be checked and or changed every 2 hours</p> <p>Review of the current 6/4/12 Toileting Program provided by the Nurse Consultant indicated Check and Change incontinent program indicated the resident will be checked every 2 to 3 hours and cleaned as necessary.</p> <p>3.1-38(a)(2)(C)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to ensure a resident at risk for pressure sores did not develop pressure sores for 1 of 6 residents reviewed for pressure sores. (Resident #F)</p> <p>Findings include:</p> <p>The Closed record for Resident #F was</p>	F000314	<p>F314</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute</i></p>	02/09/2015

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	<p>reviewed on 1/9/15 at 1:35 p.m. The resident's diagnoses included, but were not limited to, hemiplegia (weakness) due to cerebrovascular disease (stroke), pernicious anemia, urinary retention, hypertension, peripheral vascular disease, coronary artery bypass graft, anxiety, and constipation.</p> <p>The Admission assessment dated 11/21/14, indicated the resident had no pressure areas.</p> <p>The Skin/feet assessment dated 11/21/14, indicated the resident had no noted skin issues.</p> <p>The Braden scale dated 11/21/14, indicated the resident scored a "15", indicating she was at risk for developing pressure areas.</p> <p>The Braden scales dated 11/28/14 and 12/5/14, indicated the resident scored a "16", indicating she was at risk for developing pressure areas.</p> <p>12/12/14 Braden scale: "14" moderate risk</p> <p>The Admission Minimum Data Set (MDS) assessment dated 11/28/14, indicated the resident had a Brief Interview for Mental Status score of "14"</p>		<p><i>admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and statelaw.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Resident F has been discharged from the facility.</p> <p>2) How the facility identified other residents:</p> <p>A Braden assessment was completed on all residents. All residents identified as at risk will have a skin assessment completed and any issues identified will be addressed as needed.</p> <p>3) Measures put in place/ System changes:</p> <p>Licensed staff will be re-educated regarding documentation of all skin concerns on Admission/ re-admission, identifying risk factors and pressure ulcer prevention measures.</p> <p>4) How the corrective actions will be monitored:</p>	

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	<p>indicating she was cognitively intact. The resident needed extensive assist for bed mobility and transfers. She was also identified as having an indwelling foley catheter. The resident was also identified as having no pressure ulcers.</p> <p>A Physician's order dated 11/24/14, indicated the resident's foley catheter was to be monitored every shift. The foley catheter was also to be changed monthly and as needed.</p> <p>A Physician's order dated 12/10/14, indicated the resident's coccyx was to be cleaned with wound cleaner, patted dry, apply aquacel AG and cover with dry dressing every 3 days and as needed (prn).</p> <p>The pressure ulcer progress report dated 12/10/14, indicated the following:</p> <p>Stage 2 pressure ulcer to coccyx 3 centimeters (cm) x 3 cm x 0.1 cm No undermining or tunneling. Coccyx wound edges distinct. Wound bed: 100% red surrounding tissue, intact small amount of serous drainage noted. No sign of infection.</p> <p>The 12/10/14 Pressure ulcer assessment completed by the Physician, indicated the resident had a history of stroke with</p>		<p>Braden risk scores will be reviewed within 72 hours of admission/re-admission to identify residents at risk and ensure that preventative measures are put in place.</p> <p>DON/ designee will complete a skin assessment on at least 5 residents at risk for skin break down per week to ensure any identified skin concerns have been addressed and preventative measures are in place.</p> <p>The Director of Nursing/designee will be responsible for oversight.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: Feb 9, 2015</p>				

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F000325 SS=D	<p>hemiplegia and was dependent for bed mobility.</p> <p>Interview with the Wound Nurse on 1/13/15 at 10:40 a.m., indicated the resident had healed scar tissue to the coccyx and she felt that was why the area opened up.</p> <p>Interview with the Nurse Consultant on 1/13/15 at 12:30 p.m., indicated at the time of admission, the resident's daughter indicated the resident had a history of a healed pressure area on her bottom. The Consultant also indicated the resident was on a pressure reduction mattress and was incontinent of bowel but the resident did have a foley catheter and was being treated for a urinary tract infection. The consultant indicated there was no documentation to indicate the resident had a previous history of pressure ulcers.</p> <p>This Federal tag relates to Complaints IN00159866, IN00160003, and IN00161014.</p> <p>3.1-40(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a</p>				

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	<p>resident -</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review and interview, the facility failed to assess and monitor a resident who received enteral feeding through a Percutaneous Endoscopic Gastrostomy (PEG) tube following a weight loss greater than 5% in one month for 1 of 3 residents reviewed for Nutrition of the 12 residents who met the criteria for Nutrition. (Resident #D)</p> <p>Findings include:</p> <p>1. On 1/8/15 at 10:00 a.m., LPN #1 was observed administering the resident her enteral feeding through the PEG tube. The LPN indicated at the time, the resident received five boxes of enteral feeding a day.</p> <p>The record for Resident #D was reviewed on 1/7/15 at 3:05 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, aphasia, PEG tube, dementia, high blood pressure, congestive heart failure, depressive disorder, stroke, and anemia.</p>	F000325	<p>F 325 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw. Immediate actions taken for those residentsidentified: Resident D was assessed by Dietician and recommendation to increase tubefeeding was ordered. She was placed on weekly weights for review at the NARmeeting. How the facility identified otherresidents: Allresident weights have been reviewed. All residents currently triggering weightloss or weight gains per facility policy have been identified and Dietician hasreviewed and provided recommendation as needed. Measures put into place/ System changes:</p> <p>1. In-service was completed with</p>	02/09/2015

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	<p>The Quarterly Minimum Data Set (MDS) assessment dated 11/17/14 indicated the resident's cognition was severely impaired. The resident required total dependence on staff for most of her Activities of Daily Living. The resident's weight was 154 pounds with no weight loss. The resident consumed 51% or more of and greater than 501 cubic centimeters (cc) of enteral feeding.</p> <p>Review of the monthly weights were as follows: 10/4/14 151 pounds 11/5/14-154 pounds 12/8/14 144 pounds 1/7/15 142 pounds There were no further weights or reweighs recorded in the vital signs section in the resident's medical record.</p> <p>The resident had lost 10 pounds from 11/2014 to 12/2014 which was greater than 5% in one month.</p> <p>The last Registered Dietitian (RD) Progress note was an enteral assessment dated 11/19/14. She indicated the resident's Body Mass Index (BMI) was 27. Her weight was 154 pounds and her height was 64 inches. The resident's usual body weight was between 150-160 pounds. The resident's diet was nothing</p>		<p>Dietary Manager, Dietician, Director of Nursing, Assistant Director of Nursing and Restorative Nurse to review weight/re-weight policy.</p> <p>2. A review of current NAR meeting was reviewed and revisions to process were suggested.</p> <p>1. A specific weight team was established to be overseen by Restorative Nurse and Dietary Manager.</p> <p>2. Weekly NAR meeting will include DON and or Designee as well as Dietician and dietary representative and Wound Care Nurse /Designee.</p> <p>How the corrective actions will be monitored: Dietary Manager will be responsible for monitoring weights and re-weights weekly and will notify Dietician of significant weight changes to be reviewed at the weekly NAR meeting. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. Date of compliance: February 9, 2015</p>				

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	<p>by mouth and an enteral feeding of Isosource 1.5 1 can five times a day with a water flush of 200 cc every 8 hours.</p> <p>The last RD Dietary Progress note was dated 11/19/14 which indicated the resident received all nutrition and hydration via the PEG tube. The formula provides 1250 milliliters per day. The resident's weight was 154 pounds which may be stabilizing.</p> <p>The Nutrition At Risk (NAR) Progress notes dated 11/3/14 indicated the resident's weight had stabilized. The new recommendation was to discontinue from NAR.</p> <p>The current and undated Policy for Nutritional Service provided by the Nurse Consultant indicated residents with significant weight changes of 2 and 1/2% in one week, 5% in one month, or 10% in 6 months was immediately reweighed and the proper notification made. After receiving the monthly/weekly weights the Dietary Food Manager will have 48 hours to determine any significant weight changes, request any reweighs, and report significant weight changes to the DON or designee. All reweighs will be completed within 24 hours of request</p> <p>Interview with the Dietary Food Manager</p>			

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F000329 SS=D	<p>on 1/12/15 at 11:27 a.m., indicated she puts the resident's weights in the computer after she received them from the Nursing Staff. She indicated she was not sure if she had asked for a reweigh, but anyone with a 5% or greater weight loss in a month she would have asked the Nursing Staff to reweigh the resident. She further indicated she does not recall ever getting a reweigh from nursing staff. She indicated the last time the RD saw the resident was on 11/19/14 and was due to come in tomorrow.</p> <p>3.1-(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</p>				

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	<p>receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure sliding scale insulin was administered as ordered. The facility also failed to ensure blood sugars were checked as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #140)</p> <p>Findings include:</p> <p>The record for Resident #140 was reviewed on 1/8/15 at 3:09 p.m. The resident's diagnosis included, but was not limited to, diabetes.</p> <p>A Physician's order dated 12/10/14, indicated the resident was to receive Humulin Regular insulin, inject per sliding scale before meals and at bedtime. The resident was to receive the following dose of insulin based on his blood sugar.</p> <p>150-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units</p> <p>The December 2014 Medication Administration Record (MAR), indicated there was no blood sugar documented for</p>	F000329	<p>F 329 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>Immediate actions taken for those residents identified: Resident # 140 resident was assessed for signs and symptoms of hyper or hypo-glycemia, and blood sugar was checked with glucometer. No negative outcome.</p> <p>How the facility identified other residents: All residents who had physician orders for sliding scale and blood sugar checks were reviewed.</p> <p>Measures put into place/ System changes: Glitch in computer program was identified and sliding scales have been re-entered. Nurses have been in-serviced if unable to</p>	02/09/2015	

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	<p>12/12, 12/13, 12/25, and 12/29/14 at 6:59 a.m. There was no blood sugar documented on 12/17/14 at 8:00 p.m.</p> <p>The December 2014 MAR, indicated the resident's blood sugars were as follows:</p> <p>12/10/14 at 4:00 p.m., blood sugar 155. 12/11/14 at 11:00 a.m., blood sugar 235. 12/11/14 at 4:00 p.m., blood sugar 226. 12/11/14 at 8:00 p.m., blood sugar 187. 12/12/14 at 11:00 a.m., blood sugar 162. 12/14/14 at 6:59 a.m., blood sugar 292. 12/14/14 at 4:00 p.m., blood sugar 191. 12/14/14 at 8:00 p.m., blood sugar 152. 12/15/14 at 6:59 a.m., blood sugar 202. 12/15/14 at 4:00 p.m., blood sugar 277. 12/16/14 at 6:59 a.m., blood sugar 202. 12/17/14 at 6:59 a.m., blood sugar 170. 12/18/14 at 6:59 a.m., blood sugar 331. 12/18/14 at 4:00 p.m., blood sugar 216. 12/18/14 at 8:00 p.m., blood sugar 154. 12/19/14 at 4:00 p.m., blood sugar 158. 12/22/14 at 11:00 a.m., blood sugar 152. 12/22/14 at 4:00 p.m., blood sugar 250. 12/23/14 at 4:00 p.m., blood sugar 241. 12/23/14 at 8:00 p.m., blood sugar 178. 12/24/14 at 6:59 a.m., blood sugar 167. 12/25/14 at 8:00 p.m., blood sugar 215. 12/26/14 at 4:00 p.m., blood sugar 186. 12/28/14 at 6:59 a.m., blood sugar 265. 12/28/14 at 4:00 p.m., blood sugar 263. 12/28/14 at 8:00 p.m., blood sugar 205. 12/30/14 at 6:59 a.m., blood sugar 167.</p>		<p>document in MAR section of computer program to document Blood Glucose results and sliding scale dose given in nursing progress notes and notify nursing manager.</p> <p>How the corrective actions will be monitored: The Director of Nursing and or Designee will audit medication record of at least 3 residents receiving sliding scale insulin and blood sugar checks weekly to ensure compliance.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>Date of compliance: February 9, 2015</p>	

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	<p>12/31/14 at 6:59 a.m., blood sugar 166.</p> <p>There was no insulin coverage recorded for the above dates. The code entered on the computerized medication sheet was "15", indicating no insulin was required.</p> <p>The January 2015 MAR, indicated there were no blood sugars recorded on 1/1, 1/3, and 1/8/15 at 6:59 a.m.</p> <p>The January 2015 MAR, indicated the resident's blood sugars were as follows:</p> <p>1/2/15 at 6:59 a.m., blood sugar 163. 1/2/15 at 8:00 p.m., blood sugar 272. 1/5/15 at 4:00 p.m., blood sugar 164. 1/5/15 at 8:00 p.m., blood sugar 197. 1/7/15 at 4:00 p.m., blood sugar 186. 1/8/15 at 4:00 p.m., blood sugar 185.</p> <p>Again, there was no insulin coverage recorded for the above dates. The code entered on the computerized medication sheet was "15", indicating no insulin was required.</p> <p>Interview with LPN #9 on 1/8/15 at 3:30 p.m., indicated there was a problem with the computer program and the amount of insulin administered could not be documented. She further indicated the amount of insulin given should have been documented in the Nursing progress</p>						

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F000425 SS=D	<p>notes.</p> <p>Interview with the Nurse Consultant on 1/13/15 at 10:00 a.m., indicated there was a glitch in the computer system and it would not show the amount of insulin the resident received.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to ensure expired insulin was not used for 3 residents on the North Unit for 3 of 3</p>	F000425	F 425 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance.	02/09/2015			

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	<p>medication carts observed. (Residents #C, #34, and #47)</p> <p>Findings include:</p> <p>1. On 1/13/15 at 9:41 a.m., a vial of Novolin Regular insulin was observed in the medication cart for Resident #C. The insulin was dated as being opened on 12/15/14. There was a sticker on the vial indicating the insulin expired on 1/9/15.</p> <p>Review of the January 2015 Medication Administration Record (MAR) for Resident #C on 1/13/15 at 10:30 a.m., indicated the resident received the insulin on 1/11 and 1/12/15 at 8:00 a.m. and 12:00 p.m.</p> <p>2. On 1/13/15 at 9:42 a.m., a vial of Novolin Regular insulin was observed in the medication cart for Resident #34. The insulin was dated as being opened on 12/8/14. There was a sticker on the vial indicating the insulin expired on 1/4/15.</p> <p>Review of the January 2015 Medication Administration Record (MAR) for Resident #34 on 1/13/15 at 10:30 a.m., indicated the resident received the insulin 1/5-1/12/15.</p> <p>3. On 1/13/15 at 9:43 a.m., a vial of Novolin Regular insulin was observed in</p>		<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Immediate actions taken for those residents identified:</p> <p>1. Resident C expired medication was destroyed 2. Resident # 34 expired medication was destroyed 3. Resident # 47 expired medication was destroyed</p> <p>How the facility identified other residents:</p> <p>All IDDM residents receiving insulin were identified per current physician orders. All insulin was dated and current.</p> <p>Measures put into place/ System changes: In-service was presented regarding: Insulin administration policy Insulin expiration policy Pharmacy labeling policy System in place for night nurse to check insulin dates daily. How the corrective actions will be monitored: The DON/Designee will perform random audit of medication carts at least 2x/week x30 days, then weekly thereafter to ensure compliance. The results of these audits will be reviewed in Quality Assurance</p>		

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F000431 SS=D	<p>the medication cart for Resident #47. The insulin was dated as being opened on 12/15/14. There was a sticker on the vial indicating the insulin expired on 1/9/15.</p> <p>Review of the January 2015 Medication Administration Record (MAR) for Resident #47 on 1/13/15 at 10:30 a.m., indicated the resident received the insulin 1/10-1/12/14.</p> <p>Interview with LPN #3 on 1/13/15 at 9:45 a.m., indicated the insulin was to be discarded after 28 days.</p> <p>The facility policy titled "Medications with Shortened Expiration Dates" was reviewed on 1/13/15 at 11:00 a.m. The policy was provided by the Assistant Director of Nursing and identified as current. The policy indicated Novolin insulin expired 30 days after opening/puncturing or after removing from refrigerator, whichever came first.</p> <p>3.1-25(o)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate</p>		<p>Meeting monthly x3 months, then quarterly x1 for a total of 6 months. Date of compliance: February 9, 2015</p>				

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	<p>reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure insulin vials were dated when opened on 2 of 3 medication carts on the North Unit. (Medication cart #1 and #3 and Residents #22 and #42)</p> <p>Findings include:</p> <p>1. On 1/13/15 at 9:41 a.m., a vial of 70/30 insulin for Resident #22 was not dated when opened.</p>	F000431	<p>F 431 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared</p>	02/09/2015	

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F000441 SS=E	<p>Interview with LPN #7 at the time, indicated the vial of insulin should have been dated when opened.</p> <p>2. On 1/13/15 at 9:43 a.m., a vial of Lantus insulin for Resident #42 was not dated when opened. The vial of insulin was delivered to the facility on 1/9/15.</p> <p>Interview with LPN #3 at the time, indicated the Lantus should have been dated when opened.</p> <p>Interview with the Assistant Director of Nursing on 1/13/15 at 11:00 a.m., indicated that she would have expected the vials of insulin to be dated when they were opened.</p> <p>3.1-25(j)</p>		<p><i>and/or executed solely because it is required by the provisions of federal and statelaw.</i></p> <p>Immediate actions taken for those residents identified:</p> <p>1. Resident #22 Non dated insulin was replaced and new vial dated</p> <p>2. Resident # 42 Non dated insulin was replaced and new vial dated</p> <p>How the facility identified other residents: All IDDM residents receiving insulin were identified per current physician orders. All insulin was dated and current.</p> <p>Measures put into place/ System changes: In-service was presented regarding: 1. Insulin administration policy 2. Insulin expiration policy 3. Pharmacy labeling policy 4. System in place for night nurse to check insulin dates daily.</p> <p>How the corrective actions will be monitored: The DON/Designee will perform random audit of medication carts at least 2 x/week x30 days, then weekly thereafter to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. Date of compliance: February 9, 2015</p>		
	483.65 INFECTION CONTROL, PREVENT				

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	<p>SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(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.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure hands were washed after glove removal</p>	F000441	F441 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation	02/09/2015			

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	<p>for 2 of 2 glucometers observed. The facility also failed to ensure wash basins and urinals were stored properly and the facility also failed to ensure second step tuberculin skin tests were completed for 3 of 10 employee files reviewed. (Residents #34 and #91) (LPN #6, Housekeeper #1, and Activity Aide #1)</p> <p>Findings include:</p> <p>1. On 1/7/15 at 11:52 a.m., LPN #1 was observed checking Resident #91's blood sugar. The LPN put on a pair of gloves and checked the resident's blood sugar. The LPN removed the glove on her left hand and walked out of room. The lancet was in her right hand gloved hand. The LPN proceeded to place the lancet in the sharps container on the medication cart. After disposing of the lancet, she removed the glove and obtained a container of bleach wipes from the medication cart. The LPN went back into the resident's room. The LPN then put on a pair of gloves and wiped down the glucometer (the machine to check the resident's blood sugar) with the bleach wipe and then put the glucometer on a paper towel. The LPN proceeded to remove her gloves and washed her hands with soap and water. That was the first time the LPN washed her hands after glove removal.</p>		<p><i>of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified: 1. LPN#1 and #8 were re-educated regarding hand washing policy. 2. All urinals for identified residents were removed and replaced with urinals that have lids. 3. Uncovered bath basins were placed in plastic and stored at bedside. 2) How the facility identified other residents: 1. All residents receiving blood sugar checks have the potential to be affected. 2. Rounds were made to check rooms to ensure personal care items such as wash basin, urinal or bedpan were stored properly. 3. All residents requiring urinals had them replaced with urinals that have lids. 4. All current employee files were reviewed and all current employees needing a Mantoux test will receive test to ensure compliance. 3) Measures put into place/ System changes: 1. Nursing staff will be re-educated regarding glove removal, hand washing policy and storage of personal care items such as bedpans, urinals, and</i></p>				

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	<p>Interview with the North Unit Manager on 1/13/15 at 12:08 p.m., indicated LPN #1 should have washed her hands or used an alcohol gel after glove removal and prior to leaving the resident's room or immediately after disposing of the lancet in the sharps container.</p> <p>2. On 1/12/15 at 8:39 a.m., LPN #8 was observed checking Resident #34's blood sugar. The LPN washed her hands with soap and water and put on a pair of gloves. After checking the resident's blood sugar, the LPN removed her gloves and walked out of the resident's room. The LPN then proceeded down the hall to find an over bed table for the resident.</p> <p>Interview with the North Unit Manager on 1/13/15 at 12:08 p.m., indicated the LPN should have washed her hands or used an alcohol gel after glove removal and prior to leaving the resident's room.</p> <p>Review of the facility "Hand Washing" policy on 1/13/15 at 11:58 a.m., which was identified as current by the Nurse Consultant, indicated hand washing at a minimum was to be completed before putting on and after taking off gloves.</p> <p>Review of the facility policy titled "Procedure for Using Alcohol-Based</p>		<p>wash basins. 2. Human Resource will/has developed a tickler file to indicate when Mantoux test is due,, a list will then be provided to infection control nurse to ensure employees are receiving test timely. Human Resource will notify infection control nurse when new employess are hired and needing an initial Mantoux and infection control nurse will inform new employes when 2nd step is due. 4) How the corrective actions will be monitored: Rounds will be made by facility management at varied times and shifts toobserve for infection control concerns and storage of personal care items at least 5x/week. A minimum of 5 nursing staff per week will be observed performing carerequiring gloves toobserve for proper glove removal and hand washing.The Director of Nursing or designee will be responsible for oversight of these audits. E.D. will audit new employee filies to ensure compliance with Mantoux testing.This system will be ongoingThe results of these audits will be reviewed in Quality Assurance Meetingmonthly x3 months, then quarterly x1 for a totalof 6 months. 5) Date ofcompliance: Feb 9, 2015</p>		

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	<p>Hand Rub" on 1/13/15 at 11:58 a.m., which was identified as current by the Nurse Consultant, indicated an alcohol-based hand rub was to be used before exiting a resident's room.</p> <p>3. On 1/6/15 at 8:30 a.m., in room 121-1 there were two bath basins in the bathroom the first one was in a plastic bag the second one was on top of the basin in the plastic bag and it was not covered. There were two residents who resided in the room.</p> <p>On 1/12/15 at 12:04 p.m., the basins were in the room as above and on the floor.</p> <p>4. On 1/6/15 at 2:30 p.m., in room 125 there was an urinal sitting on the back of the toilet seat uncovered in the bathroom.</p> <p>On 1/12/15 at 12:06 p.m., the urinal was observed in the bathroom uncovered and with no lid on it. There were two residents who resided in the room.</p> <p>5. On 1/6/15 at 2:29 p.m., in Room 120 there was an urinal sitting on the back of the toilet. The urinal was uncovered and had no lid. There were two residents who resided in the room.</p> <p>6. On 1/6/15 at 1:23 p.m., in Room 305-1 there was an urinal on the head board of the bed. The urinal had urine in</p>			

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	<p>it and the lid was not covering the top. There were two residents who resided in the room.</p> <p>7. On 1/6/15 at 10:25 a.m., in Room 311 there were two urinals on the side rails of the bed, the lids to both of them were off.</p> <p>On 1/12/15 at 11:45 a.m. the urinals were observed on the night stand and did not have any lids on them.</p> <p>Interview with the Housekeeping supervisor at the time, indicated he was unsure if his housekeepers were responsible for covering or picking up the urinals and/or wash basins. He further indicated he was aware the urinals needed to be stored up off the floor and not on the night stands or side rails. He indicated they were to be placed in plastic bags.</p> <p>Interview with the Nurse Consultant on 1/12/15 at 2:00 p.m., indicated the urinals and/or wash basins should not be stored on top of over bed tables or night stands, on the side rails or on the bathroom rail. She further indicated the basins should be in plastic bags. She indicated the facility did not have a policy in regards to the storage of urinals and/or wash basins.</p> <p>8. The Employee files were reviewed on</p>						

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	<p>1/13/15 at 9:45 a.m.</p> <p>A. LPN #6 was hired on 2/20/14 and had first step Mantoux test administered on 2/20/14 and read on 2/23/14. There was no evidence a second step Mantoux test had been completed.</p> <p>B. Housekeeper #1 was hired on 2/20/14 and had first step Mantoux test administered on 2/20/14 and read on 2/24/14. There was no evidence a second step Mantoux test had been completed.</p> <p>C. Activity Aide #1 was hired on 1/6/14 and had a first step Mantoux test administered on 1/20/14 and read on 1/23/14. There was no evidence a second step Mantoux test had been completed.</p> <p>Interview with the Infection Control Nurse/ADON on 1/13/15 at 11:30 a.m., indicated the employee was to come in and go to a Nurse's station and whoever was certified would administer the Mantoux. She further indicated they were then instructed at that time, to come back 10 to 14 days for another Mantoux test. She indicated the Human Resource Manager was to follow up on the employees and remind them they needed their second step Mantoux test.</p>			

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F000463 SS=D	<p>Review of the current Tuberculosis Testing of Healthcare Workers Policy provided by the Interim Director of Nursing indicated "Initial test will be a two-step procedure, with the first does given as soon as possible and the second 'booster dose' given 1 to 3 weeks after the first."</p> <p>Interview with the Human Resource Manager on 1/13/15 at 11:50 a.m., indicated the second step Mantoux tests had not been completed for the above mentioned employees.</p> <p>3.1-18(b)(1)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview the facility failed to ensure each resident room had a functioning call system for 2 of 3 Units observed. (The North and South Units).</p> <p>Findings include:</p> <p>1. On 1/6/15 at 8:49 a.m., the call light for Room 108-2 was pressed. At that time, the call light did not light up</p>	F000463	<p>F463</p> <p>The facility requestpaper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the</i></p>	02/09/2015

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	<p>outside of the room door or make any type of noise.</p> <p>On 1/12/15 at 12:04 p.m., the call light in room 108-2 was pressed again. At that time, the light outside the room door did not light up. The Maintenance Director unplugged the call system and then plugged it back in. After he did this, the call light lit up outside the resident's door. There was one resident who resided in the room.</p> <p>Interview with the Maintenance Director at the time, indicated there was probably something wrong with call light and he would change it out.</p> <p>2. On 1/5/15 at 2:21 p.m. LPN #7 was observed to press the call pad button in Room 216 which was inside of the posey netting on the bed. The call light did not light up outside of the room or make any type of noise or light up on the panel at the Nurses station. There was two residents who resided in the room.</p> <p>Interview with the Maintenance Director on 1/12/15 at 12:05 p.m., indicated he had fixed the call light on 1/5/15 after he was notified by Nursing Staff.</p> <p>3.1-19(u)(1)</p>		<p><i>provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and statelaw.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Call lights in rooms 108-2 and 216 were repaired by maintenance.</p> <p>2) How the facility identified other residents:</p> <p>A check of all resident call lights and the call light system has been completed.</p> <p>3) Measures put into place/ System changes:</p> <p>Employees will be in serviced on reporting any malfunctions immediately to the maintenance department and filling out work order form.</p> <p>Maintenance will audit at least 5 different rooms per week to ensure call lights are functioning properly.</p> <p>The Maintenance Director will be responsible for oversight of the audits.</p> <p>4) How the corrective actions will be monitored:</p>				

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to keep the resident's environment clean and in good repair related to marred and gouged walls and doors, dusty ceiling vents, disrepair towel racks and dirty floor registers for 3 of 3 units. (The North, South, and PCU Units).</p> <p>Findings include:</p> <p>1. Observation during the Environmental Tour on 1/12/15 at 11:40 p.m. the following was observed on the North Unit:</p> <p>A. The bathroom wall and door was marred and gouged in Room 118. There were two residents residing in the room.</p>	F000465	<p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: Feb 9, 2015</p> <p>F465 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified: Repairs have been made as appropriate to Rooms 118, 131, 127, 216, 221, 223 and 301. Items that could not be repaired were ordered and will be installed upon delivery. The facility</p>	02/09/2015

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	<p>B. The inside of the bathroom door was gouged in Room 131. There were two residents who resided in the room.</p> <p>C. The floor register was dirty with crumbs noted in the vent and the cover was falling off. The bottom of the room chair was falling apart in Room 127. There were two residents who resided in the room.</p> <p>2. Observation during the Environmental Tour on 1/12/15 at 11:40 p.m. the following was observed on the South Unit:</p> <p>A. The plaster on the lower part of the wall in the bathroom was chipped below the two silver towel bars in Room 216. There were two residents who resided in the room.</p> <p>B. The lower part of the closet doors were marred with black scuff marks. The walls next to the toilet and the wall under the towel racks were both marred with black scuff marks in Room 221. There were two residents who resided in the room.</p> <p>C. In Room 223 there were crumbs on the control panel by the knobs in floor register. There were two silver brackets</p>		<p>cleaned the ceiling vents in rooms 302, 305, 306, and 307 at time of findings. 2) How the facility identified other residents: Audit will be completed of all resident rooms available for occupancy to identify any other environmental concerns. 3) Measures put into place/ System changes :1. Maintenance and Housekeeping department will develop a schedule to complete inspection and repairs on at least 3 resident rooms per week until all rooms available for occupancy are completed. 2. A checklist of cleaning assignments has been developed by the Housekeeping Supervisor to be used daily. All housekeeping staff has been in-serviced. Maintenance and Housekeeping Supervisors will be responsible for oversight. 4) How the corrective actions will be monitoredThe Housekeeping Supervisor will report [results of audits of cleaning assignments monthly to Q/A for six months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: Feb 9, 2015</p>	

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F000490 SS=E	<p>of a towel rack on the wall in the bathroom with bar between them. One of the brackets was observed falling off and pulling away from the wall. There were two residents who resided in the room.</p> <p>Observation during the Environmental Tour on 1/12/15 at 11:40 p.m. the following was observed on the PCU Unit:</p> <p>A. The bathroom ceiling vents in rooms 301, 302, 305, 306, and 307 were dusty and dirty. There were two residents residing in each of the above mentioned rooms.</p> <p>Interview with the Housekeeping and Maintenance Directors at that time, indicated all of the above was in need of cleaning and/or repair.</p> <p>This Federal Tag relates to Complaint IN00159866.</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,</p>				

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	<p>mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview the facility failed to ensure measures were in place for the facility to be administered efficiently and effectively to attain the highest practicable well- being of the resident related to monitoring staff for the required certifications upon hire and annually for CNA's. (CNA's #1, #2, #3, & #4) (Employees #1 & #2)</p> <p>Findings include:</p> <p>The facility Employee Files were reviewed on 1/13/15 at 9:45 a.m. The following Employees had not completed the CNA certification.</p> <p>Employee #1 Hired as a CNA on 4/25/14 Worked as a CNA last on 12/28/14, 12/31/14, 1/2/15, 1/4/15, 1/8/15, 1/10/15, and 1/13/15.</p> <p>Employee #2 Hired as a CNA on 4/25/14 Worked as a CNA last on 12/28/14, 12/29/14, 1/1/15, 1/2/15, 1/5/15, 1/6/15, 1/7/15, 1/8/15, 1/10/15, 1/11/15, and 1/12/15.</p> <p>The following CNA's had worked in the facility in December 2014 and January</p>	F000490	<p>F490 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified: All staff identified as not having current certifications were immediately suspended. CNA #1,2,3, and 4: 2 CNA's renewed certifications and returned to work 2 CNA's did not renew certification and were terminated from employment. Employee #1 and #2 were terminated from employment. 2) How the facility identified other residents: An audit was completed for all nursing staff to ensure certifications and licensure was current. 3) Measures put into place/ System changes: Human Resources manager will utilize licensure tracking tool to track licensure and certification expiration dates. Human Resources manager will verify</p>	02/09/2015			

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	<p>2015 without current CNA certificates.</p> <p>CNA #1: Hired on 1/22/2013. CNA certificate expired on 11/28/14. Worked as a CNA on 12/29/14, 12/31/14, 1/2/15, 1/7/15, 1/8/15, 1/9/15, and 1/12/15.</p> <p>CNA #2 Hired on 10/31/1996 CNA certificate expired on 8/14/14 Worked as a CNA on 12/29/14, 12/30/14, 12/31/14, 1/3/15 1/4/15, 1/5/15, 1/6/15, 1/8/15, 1/9/15, 1/12/15, and 1/13/15.</p> <p>CNA #3 Hired on 4/17/14 CNA certificate expired on 11/19/14 Worked as a CNA on 12/28/14, 12/29/14, 1/1/15, 1/2/15, 1/6/15, 1/7/15, 1/9/15, 1/10/15, 1/11/5, and 1/12/15.</p> <p>CNA #4 Hired on 4/30/14 CNA certificate expired on 5/18/14 Worked as a CNA on 12/28/14, 12/30/14, 1/31/14, 1/1/15, 1/6/15, 1/7/15, 1/8/15, 1/9/15, and 1/10/15.</p> <p>When interviewed on 1/13/15 at 12:00 p.m., the facility Administrator indicated the procedure was for the HR (Human Resource) manager to verify the CNA's</p>		<p>certifications and licensure are current upon hire, and expiration dates will be added to the tracking tool. HR manager will audit tracking tool monthly to identify certifications/licensure that will expire in the next30 days, and verify weekly until all are renewed. The Executive Director will beresponsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meetingmonthly x3 months, then quarterly x1 for a total of 6 months. 5) Date ofcompliance: Feb 9, 2015</p>				

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F000494 SS=D	<p>have current certification at the time of hire and annually after that. The facility Administrator also indicated the procedure was also for the HR manager to ensure the employee had completed the CNA testing for certification within 120 days of their hire dates.</p> <p>3.1-(13)(q)</p> <p>483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.</p> <p>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.</p> <p>Based on record review and interview the facility failed to ensure 2 employees</p>	F000494	F494 The facility requestspaper compliance for	02/09/2015			

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	<p>currently working in the facility as CNA's had obtained their CNA certification within 120 days of their hire date. (Employee's #1 and #2)</p> <p>Findings include:</p> <p>The facility Employee Files were reviewed on 1/13/15 at 9:45 a.m. The following Employees had not completed the CNA certification.</p> <p>Employee #1 Hired as a CNA on 4/25/14 Worked as a CNA last on 12/28/14, 12/31/14, 1/2/15, 1/4/15, 1/8/15, 1/10/15, and 1/13/15.</p> <p>Employee #2 Hired as a CNA on 4/25/14 Worked as a CNA last on 12/28/14, 12/29/14, 1/1/15, 1/2/15, 1/5/15, 1/6/15, 1/7/15, 1/8/15, 1/10/15, 1/11/15, and 1/12/15.</p> <p>When interviewed on 1/13/15 at 11:50 a.m., the Human Resource Manager indicated she was unaware the above employees had not completed their CNA certification within 120 days of their employment..</p> <p>When interviewed on 1/13/15 at 12:00 p.m., the facility Administrator indicated</p>		<p>this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> 1) Immediate action taken for those residents identified: Employee #1 and #2 were immediately suspended and terminated from employment. 2) How the facility identified other residents: An audit was completed for all nursing staff to ensure certifications and licensure was current. 3) Measures put into place/ System changes: Human Resources manager will utilize licensure tracking tool to track licensure and certification expiration dates. Human Resources manager will verify certifications and licensure are current upon hire, and expiration dates will be added to the tracking tool. HR manager will audit tracking tool monthly to identify certifications/licensure that will expire in the next 30 days, and verify weekly until all are renewed. The Executive Director will be responsible for oversight of these</p>				

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F000496 SS=E	<p>the procedure was for the HR (Human Resource) Manager to ensure that the employee complete the CNA testing for certification within 120 days of their hire dates.</p> <p>3.1-14(b)(2)(A) 3.1-14(b)(2)(B)</p> <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING 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</p>		<p>audits 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: Feb 9, 2015</p>	

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	<p>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 record review and interview, the facility failed to ensure CNA certificates were current for 4 CNA's currently working in the facility. (CNA's #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>The facility Employee files were reviewed on 1/13/15 at 9:45 a.m. The following CNA's had worked in the facility in December 2014 and January 2015 without current CNA certificates.</p> <p>CNA #1: Hired on 1/22/2013. CNA certificate expired on 11/28/14. Worked as a CNA on 12/29/14, 12/31/14, 1/2/15, 1/7/15, 1/8/15, 1/9/15, and 1/12/15.</p> <p>CNA #2 Hired on 10/31/1996 CNA certificate expired on 8/14/14 Worked as a CNA on 12/29/14, 12/30/14, 12/31/14, 1/3/15 1/4/15, 1/5/15, 1/6/15, 1/8/15, 1/9/15, 1/12/15, and 1/13/15.</p> <p>CNA #3</p>	F000496	<p>F496 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified: All staff identified as not having current certifications were immediately suspended. CNA #1, 2, 3, and 4: 2 CNA's renewed certifications and returned to work 2 CNA's did not renew certification and were terminated from employment. 2) How the facility identified other residents: An audit was completed for all nursing staff to ensure certifications and licensure were current. 3) Measures put into place/ System changes: Human Resources manager will utilize licensure tracking tool to track licensure and certification</p>	02/09/2015			

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	<p>Hired on 4/17/14 CNA certificate expired on 11/19/14 Worked as a CNA on 12/28/14, 12/29/14, 1/1/15, 1/2/15, 1/6/15, 1/7/15, 1/9/15, 1/10/15, 1/11/5, and 1/12/15.</p> <p>CNA #4 Hired on 4/30/14 CNA certificate expired on 5/18/14 Worked as a CNA on 12/28/14, 12/30/14, 1/31/14, 1/1/15, 1/6/15, 1/7/15, 1/8/15, 1/9/15, and 1/10/15.</p> <p>When interviewed on 1/13/15 at 11:10 a.m., the Interim Director of Nursing indicated the above CNA's did not have current certificates and were currently still working as CNA's in the facility.</p> <p>When interviewed on 1/13/15 at 11:50 a.m., the Human Resources Manager indicated she was unaware of the CNA's working with expired certificates.</p> <p>When interviewed on 1/13/15 at 12:00 p.m., the facility Administrator indicated the procedure was for the HR (Human Resource) Manager to verify the CNA's have current certification at the time of hire and annually after that.</p> <p>3.1-14(e)</p>		<p>expiration dates. Human Resources manager will verify certifications and licensure are current upon hire, and expiration dates will be added to the tracking tool. HR manager will audit tracking tool monthly to identify certifications/licensure that will expire in the next30 days, and verify weekly until all are renewed. The Executive Director will beresponsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meetingmonthly x3 months, then quarterly x1 for a total of 6 months. 5) Date ofcompliance: Feb 9, 2015</p>	

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the resident's medical record was accurate related to providing the correct height of a resident for 1 of 3 residents reviewed for nutrition of the 12 residents who met the criteria for nutrition. (Resident #48)</p> <p>Findings include:</p> <p>The record for Resident #48 was reviewed on 1/7/15 at 11:18 a.m. The resident had just been admitted to the facility on 10/10/14.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 10/17/14 indicated the resident's height was recorded as 66 inches with a weight of 108 pounds.</p>	F000514	<p>F 514 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw. Immediate actions taken for those residentsidentified: Resident # 48 height has been re-measured and recorded in medical record How the facility identified otherresidents Allmedical records have been reviewed for heights to ensure correct heights werepresent and re-measured as</p>	02/09/2015

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	<p>Review of nutritional assessment dated 10/24/14 indicated the resident's Body Mass Index (BMI) was less than 19.</p> <p>Review of the Dietary Progress note dated 10/23/14 indicated the resident was high risk for malnutrition due to underweight status and a BMI of 17.</p> <p>Review of the history and physical from the hospital dated 10/10/14 indicated the resident was 5 foot 6 inches tall.</p> <p>Review of the resident's height in the vital sign section of the medical record indicated her height was obtained on 10/17/14 while standing.</p> <p>Interview with LPN #2 on 1/7/15 at 10:35 a.m., indicated she had not recorded the resident's height in the computer. She indicated the resident did not look like she was 5 foot 6 inches tall. She looked more like 5 foot 3 inches tall. LPN #2 obtained the resident's height while the resident was lying down and the new height was 61 inches (5 foot 1 inch) tall.</p> <p>Interview with the Dietary Food Manager on 1/8/15 at 10:00 a.m., indicated she was the person who documents the resident's height in the computer. She</p>		<p>required. Measures put into place/ System changes: Nursing staff and dietary manager will be re-educated on policy for measuring height and recording accurately. How the corrective actions will be monitored: The DON/designee will review admission documentation within 72 hours to ensure accurate height is present and verified. The result of these audits will be reviewed in QA meeting monthly x3 months, then quarterly x1 for a total of 6 months. Date of compliance: February 9, 2015</p>	

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	<p>was also the person who completed the nutrition portion on the MDS. She further indicated she did look at the resident, however she did not realize she was not 5 foot 6 inches tall. She indicated she had documented the inaccurate height.</p> <p>3.1-50(a)(2)</p>				