

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2012
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 13, 14, 15, 16, 19 and 20, 2012</p> <p>Facility number: 000271 Provider number: 155402 AIM number: 100291260</p> <p>Survey team: Rita Mullen, RN Michelle Carter, RN Michelle Hosteter, RN W. Chris Greeney, Medical Surveyor</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 25 Medicaid: 51 Other: 12 Total: 88</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/29/12 by Suzanne Williams, RN</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F0164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to provide privacy for a resident during the medication pass for 1 of 2 residents observed receiving insulin. (Resident #18)</p> <p>Findings include:</p>	F0164	<p>F164</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: Resident # 18 was</p>	12/20/2012	

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	<p>In an observation during medication pass for Resident # 18 on 11/16/12 at 11 A.M., the resident received insulin from LPN # 3 without shutting the door or pulling the privacy curtain in the resident's room. The resident had his lower abdomen exposed.</p> <p>In an interview with Resident #18 on 11/13/12 at 10:30 A.M., he indicated he was concerned with privacy. The resident indicated when they come in, "They leave the door and the curtain open. They give us meds in bathroom. I'd rather they wait."</p> <p>3.1-3(p)(2)</p>		<p>interviewed by nursing administration and it was determined he did have some concerns with privacy. He has been informed the staff involved will be educated and all licensed nursing will be in serviced on providing privacy during medication pass. He stated he was glad the facility in putting a plan in place and was satisfied with the follow up.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who receive medications have the potential to be affected therefore nursing administration will observe med passes on all licensed nursing by date of compliance to assure privacy is being</p>		

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			<p>maintained.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The SDC/Designee will complete in servicing and competency checks on all licensed nurses to include providing privacy during medication administration. Active nurses will have the in service and competency checks completed by date of compliance and PRN nurses will complete prior to first scheduled shift. LPN # 3 was educated on providing privacy during med pass</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The SDC/Designee will</p>		

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			perform 2 med pass observations and competency checks weekly x 4 weeks the biweekly x 4 weeks, then monthly x 3 months until 95% compliance is achieved. Any negative patterns will be taken to PI monthly for further review and recommendations.		

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <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 promote dignity and respect by not waiting for permission to enter a resident's room (Resident #30) and not giving a resident (#51) a choice related to clothing protection, for 2 residents randomly observed.</p> <p>Findings include:</p> <p>1. During observation of the assisted dining area on 11/13/12 at 11:45am, CNA #7 brought Resident #51 to the area. CNA #7 retrieved a clothing protector and secured it around Resident #51's neck. During the observation, Resident #51 was overheard to say she didn't want to wear it. The CNA responded "you need it to protect your clothing."</p> <p>During interview with Resident #51 at 11:57am on 11/13/12, Resident #51 stated regarding the clothing protector, "They told me I had to." When asked if she wanted to wear one, Resident #51 stated "No."</p>	F0241	<p>F241</p> <p>1. Corrective action for the residents affected by the alleged deficient practice: Resident # 51 will be given the choice of wearing her clothing protector with each meal and if refuses the refusal will be honored by staff. Resident is not interview able due to diagnosis of end stage dementia. Resident # 30 was interviewed by nursing administration to assure no harm had incurred and none was noted. Resident # 30 has been informed the staff will be in-serviced on promoting dignity and respect to our</p>	12/20/2012			

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			<p>residents. No negative outcomes were noted.</p> <p>2. Corrective actions taken for those residents having the potential to be affected: Residents have the right to have their dignity and respect promoted. They have the right to make a choice related to clothing protectors and should expect staff to wait for permission from them to enter their room. Residents will be informed that the facility will in service staff on dignity and respect by the Social Service Director/Designee by date of compliance.</p> <p>3. Measures/Systemic changed put into place to assure the alleged deficient The Social Service Director/Designee will in</p>		

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	2. On 11/13/12 at 3:03 PM, during an interview with Resident #30, CNA #8 knocked on the door and walked into the room before receiving a response. She indicated she did so because the		service staff on the policy and procedure of treatment of residents with dignity and respect by date of compliance. Nursing assistants # 7 and 8 have been educated on respect and dignity by Nursing Administration. 4. Corrective actions to be monitored to ensure the alleged deficient practice does not re occur: Social Service or designee will interview 5 residents weekly x 4 weeks, then 5 residents' bi-weekly x 4 weeks then monthly until 95 % compliance is achieved. Any negative patterns will be presented to Pi monthly for review and or recommendations.		

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	<p>resident does not normally have the door shut.</p> <p>In an interview with LPN # 3 on 11/13/12 at 3:15 P.M., she indicated staff should wait for an answer before coming in.</p> <p>3.1-3(t)</p>				

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F0243 SS=B	<p>483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP</p> <p>A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>Based on interview, observation and record review, the facility failed to provide a private area for Resident Council meetings. This had the potential to affect the 10 to 15 residents who regularly attend the monthly Resident Council meetings.</p> <p>Findings include:</p> <p>During an interview with the Resident Council President, on 11/13/12 at 10:30 A.M., he indicated there is no place to meet that is private, and they can't have a place that is big enough for the group to meet that is private.</p> <p>The Resident Council Minutes, for the months of January to October 2012, were reviewed on 11/13/12 at 9:00 A.M. The minutes indicated the main dining room was used for Resident</p>	F0243	<p>F 243</p> <p>1. Corrective action for those residents affected by alleged deficient practice: The resident council president has been informed that the facility will provide a private area for the resident council meetings going forward. No negative outcomes were noted.</p> <p>2. Corrective action for those residents having the potential to be affected:</p>	12/20/2012
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	<p>Council meetings. Between 10 to 15 residents attended the monthly meetings.</p> <p>During an observation of the main dining room, on 11/13/12 at 11:30 A.M., the area was noted to be a large, open area without doors and along a main hallway where staff, visitors and other residents frequent.</p> <p>During an interview with the Director of Nursing, on 11/19/12 at 1:45 P.M., she indicated the only private place is the facility chapel, where residents can meet with visitors and use the phone in private.</p> <p>During an observation of the Chapel, on 11/13/12 at 10:30 A.M., there were three long church benches, two organs and a speaking podium. These items limited the space available for residents, using wheelchairs, who would wish to attend resident council meetings.</p> <p>3.1-3(i)</p>		<p>Residents who attend the monthly resident council meeting have the potential to be affected therefore the meeting will be held in that activity room behind closed doors. The staff will assist with assuring the activity room has adequate room to allow residents to attend.</p> <p>3. Measures/Systems put in place to assure alleged deficient practice does not re occur: The Social Service Director will in service the resident council president and the department managers involved in resident council that they have to provide a private room with adequate space for the residents wishing to attend the meeting by date of compliance.</p>		

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			<p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The ED will validate monthly the meeting is taking place in an appropriate area monthly x 3, then quarterly x 2. Any negative trends or patterns will be presented to PI monthly for review/recommendations</p>		

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F0247 SS=B	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure residents were provided a notice of roommate change. This deficiency affected 3 of 3 residents reviewed for roommate change in a sample of 3 who met the criteria for notice of roommate change. (Residents #18, 34, and 71)</p> <p>Findings include:</p> <p>During clinical record reviews for Residents #18, 34, and 71, on 11/19/12 at 10:00 A.M., documentation related to notification of roommate change was not found.</p> <p>During an interview with the Social Services Director (SSD) on 11/19/12 at 11:00 A.M., she indicated the facility does not notify residents when they will be receiving a new roommate or when/if a roommate is moving out. The facility documents on forms titled "Room Change Notification" if a resident requests a room change.</p> <p>A policy titled "Resident Room</p>	F0247	<p>F247</p> <p>1. Corrective action for the residents affected by the alleged deficient practice: Social Service has interviewed residents # 18 and 34 and there have been no negative outcomes. Both residents have been informed that the staff will be educated on informing residents of roommate changes and required documentation of such. Resident # 71 no longer resides in facility.</p> <p>2. Corrective action for those residents who have the potential to be affected by the alleged deficient practice: Residents who receive a roommate have the</p>	12/20/2012	

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	<p>Relocation," received from the SSD on 11/19/2012 at 1:45 P.M., indicated the following: "The Social Services staff develop a plan to ensure that needs and concerns related to the resident's ability to cope and adjust to the relocation are addressed by taking the following steps. 1. Providing the resident, legal guardian, and interested family member with a verbal notice and documenting this in the medical chart.4. Informing the resident or legal guardian when he or she is receiving a new roommate."</p> <p>Additionally, the policy stated "...The Social Services staff document the resident's response to the move in the medical record."</p> <p>3.1-3(v)(2)</p>		<p>potential to be affected therefore the social service director and or designees will provide a notice of roommate change to residents and or family members receiving roommates from survey exit forward and ensure appropriate documentation.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: SSD/Designee will in service staff on policy and procedure for roommate notice change by 12/20/12 including documentation requirements as well.</p> <p>4. Corrective actions will be monitored to ensure alleged deficient practice does not re occur by:</p>		

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			Social Service/Designee will audit clinical records of roommate changes to ensure the policy and procedure is being followed until 95% compliance is achieved. Any negative trends or patterns will be presented to PI monthly for review and or recommendations.	

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to provide medically-related social services to a resident with the diagnosis of dementia and with behaviors. This deficiency affected 1 of 10 residents with a dementia diagnosis. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #28 was reviewed on 11/15/12 at 2:00 P.M.</p> <p>Diagnoses for Resident #28 included, but were not limited to, dementia, hypertension, and hypothyroidism.</p> <p>A care plan titled "Dementia with Behaviors," dated 7/17/12, indicated the following:</p> <p>Problem: Resident has history of thinking staff is trying to harm her. She has diagnosis of dementia and requires staff to intervene and reorient to reality. Resident gets very anxious at times.</p>	F0250	<p>F250</p> <p>1. Corrective actions for the resident affected by the alleged deficient practice: Resident # 28 has been assessed to ensure no harm has incurred with none noted. Resident # 28 has had her care plan reviewed and updated by SSD to reflect appropriate interventions to address her behaviors.</p> <p>2. Corrective action taken for those residents who have the potential to be affected by the alleged deficient practice: Residents with the dx of dementia and having behaviors have the potential to be affected.</p>	12/20/2012			

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	<p>Goals: Resident will not exhibit any fearful behaviors thru next review.</p> <p>Approaches: Introduce yourself to resident. Gain resident's trust. Explain tasks prior to beginning ADL (Activities of Daily Living) care. Educate on the need to provide ADL care.</p> <p>Another care plan titled "Dementia," dated 7/17/12, indicated the following:</p> <p>Problem: Resident thinks she is going home each day after an activity and may ask to leave in the middle of the program. Resident may be nervous and tearful at times and forget where she is.</p> <p>Goals: 1. Resident will attend activities of residents choice daily thru next review. 2. Resident will allow staff members to redirect/reorient to reality thru next review.</p> <p>Approaches: 1. Activity staff will sit with resident during the program to encourage to remain at the program. 2. Assist resident to and from group activities.</p>		<p>An audit has been conducted by the Social Service Director to ensure their care plans are updated and reviewed to assure appropriate interventions are in place to meet the needs of these residents by date of compliance.</p> <p>3. Measures/Systems put in place to ensure alleged deficient practice does not re occur: The SSD/Designee will in service nursing staff on following plan of care with appropriate behavior interventions. Nursing will be in serviced by date of compliance and any PRN staff will be in serviced by first scheduled shift.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by:</p>	

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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906		
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	<p>3. Sit resident with other residents of similar interests.</p> <p>4. Provide calendar activity for date.</p> <p>5. Staff to reorient/redirect to reality.</p> <p>6. Provide reassurance/support.</p> <p>7. Encourage activity participation.</p> <p>During an observation on 11/14/12 at 1:30 P.M., Resident #28 was sitting in her wheelchair at the central nurses station. Resident #28 was confused, talked loudly, exhibited anxious & fearful behavior, and counted repetitively, "5,6,7". Resident stated, "Let the boys fight it out!" She repeatedly told/ asked, for staff to leave her alone, upon their approach to redirect. At least 7 different staff members tried to redirect, including nurses, certified nursing assistants (CNAs), and the activity director. As the afternoon shift change approached, several staff gathered at the nurses station. As Resident #28's anxiety increased, more staff attempted to approach her. She refused to let staff assist her. At 2:00 P.M., a nurse asked Resident #28 about hand pain. Pain medications were administered. Resident #28 was brought back into the central nurses station area. A staff member, from a local service for council on aging, sat and talked and provided calming reassurance with</p>		<p>The SSD/Designee will observe 3 nursing staff members weekly to assure appropriate interventions are being followed per plan of care x 4 weeks, then 3 staff members bi-weekly, then monthly until 95% compliance. Negative trends and patterns will be presented to PI monthly for review and or recommendations.</p>		

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	<p>Resident #28. Staff were not observed to make an attempt to redirect Resident # 28 with items or activities she enjoys. Staff members approached the resident from behind the wheelchair and leaned over her, from the back, as they held onto wheelchair handles in an attempt to take her elsewhere. Staff failed to introduce themselves to Resident #28 in a calm and reassuring manner. Additionally, staff failed to make redirection attempts with items or activities that were care planned.</p> <p>During an interview with RN #5 on 11/14/12 at 2:10 P.M., it was indicated typical behaviors were exhibited, earlier that day, by Resident #28. He indicated she counts, "5,6,7," continually. Additionally, RN #5 indicated Resident #28 liked to read and reads well.</p> <p>Activity notes, dated 4/19/12, indicated Resident #28 "loves to look at magazines, loves pictures of birds, dogs, cat, babies. She is of Catholic faith. Loves to sit outside on porch."</p> <p>LPN #6 indicated, during an interview on 11/15/12 at 2:25 P.M., when Resident #28 gets anxious and talkative, in order to redirect her, give</p>						

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	<p>her magazines or a book. She especially likes magazines with dogs or birds. Or staff can write words or sentences on a paper and she can read them, out loud. LPN #6 continued to indicate that Resident #28 liked to talk and count, repetitively. Counting, aloud, "5,6,7", was a normal behavior.</p> <p>On 11/19/12 at 3:31 P.M. the Activity Director (AD) indicated, during an interview, Resident #28 went to coffee hour and current events every morning. On Monday, Wednesday, and Friday mornings, Resident #28 went to small group discussion for lower cognitive functioning residents. She enjoys musical events, also. The AD indicated when Resident #28 displays anxious, confused, and fearful behavior, staff were supposed to redirect her and reorient her to reality.</p> <p>During an interview on 11/20/12 at 9:30 A.M. with the Director of Nursing (DON), she indicated Resident #28 was not able to be reoriented or educated due to the dementia diagnosis. She indicated these interventions/approaches are inappropriate, as indicated on Resident #28's care plans.</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for a resident with low cognitive status (Resident #28) and regarding non-pharmacological interventions (Resident #80). This deficiency affected 2 of 20 residents whose care plans were reviewed.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #28 was reviewed on 11/15/12 at 2:00 P.M.</p>	F0279	<p>F279</p> <p>1. Corrective action for residents affected by alleged deficient practice: Resident # 28 has had her care plan updated to reflect appropriate interventions related to behaviors by the ICPT. Resident # 80 has had her care plan updated by Social Service</p>	12/20/2012	

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	<p>Diagnoses for Resident #28 included, but were not limited to, dementia, hypertension, and hypothyroidism.</p> <p>A care plan, titled "Dementia with Behaviors," dated 7/17/12, indicated the following:</p> <p>Problem: Resident has history of thinking staff is trying to harm her. She has diagnosis of dementia and requires staff to intervene and reorient to reality. Resident gets very anxious at times.</p> <p>Goals: Resident will not exhibit any fearful behaviors thru next review.</p> <p>Approaches: Introduce yourself to resident. Gain resident's trust. Explain tasks prior to beginning ADL (Activities of Daily Living) care. Educate on the need to provide ADL care.</p> <p>Another care plan titled "Dementia," dated 7/17/12, indicated the following:</p> <p>Problem: Resident thinks she is going home each day after an activity and may ask to leave in the middle of the program. Resident may be nervous and tearful at times and</p>		<p>Director/Designee to include non pharmacological interventions prior to administering Lorazepam.</p> <p>2. Corrective actions taken for the residents who have the potential to be affected by the alleged deficient practice: Residents who have a diagnosis of dementia and have behaviors will have their care plans reviewed for appropriate interventions by SSD by date of compliance. Residents who have an order for PRN anti-anxieties will have their clinical records and care plan reviewed by Social Service Director/designee to assure there are non-pharmacological interventions on their plan of care by the date of</p>	

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	<p>forget where she is.</p> <p>Goals: 1. Resident will attend activities of residents choice daily thru next review. 2. Resident will allow staff members to redirect/reorient to reality thru next review.</p> <p>Approaches: 1. Activity staff will sit with resident during the program to encourage to remain at the program. 2. Assist resident to and from group activities. 3. Sit resident with other residents of similar interests. 4. Provide calendar activity for date. 5. Staff to reorient/redirect to reality. 6. Provide reassurance/support. 7. Encourage activity participation.</p> <p>During an observation on 11/14/12 at 1:30 P.M., Resident #28 was sitting in her wheelchair at the central nurses station. Resident #28 was confused, talked loudly, exhibited anxious & fearful behavior, and counted repetitively, "5,6,7". Resident stated, "Let the boys fight it out!" She repeatedly told/ asked, for staff to leave her alone, upon their approach to redirect. At least 7 different staff members tried to redirect, including nurses, certified</p>				<p>compliance.</p> <p>3. Measures/Systems put in place to assure alleged deficient practice does not re occur: Social Service Director/Designee will in service ICPT on assuring appropriate interventions are in place on the plan of care for residents with a diagnosis of Dementia and has behaviors as well by date of compliance. SSD will review orders with anti anxiety medications to assure those residents have a plan of care to include non pharmacological interventions ongoing.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Social Service Director /Designee will</p>		

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	<p>nursing assistants (CNAs), and the activity director. As the afternoon shift change approached, several staff gathered at the nurses station. As Resident #28's anxiety increased, more staff attempted to approach her. She refused to let staff assist her. At 2:00 P.M., a nurse asked Resident #28 about hand pain. Pain medications were administered. Resident #28 was brought back into the central nurses station area. A staff member, from a local service for council on aging, sat and talked and provided calming reassurance with Resident #28. Staff were not observed to make an attempt to redirect Resident # 28 with items or activities she enjoys. Staff members approached the resident from behind the wheelchair and leaned over her, from the back, as they held onto wheelchair handles in an attempt to take her elsewhere. Staff failed to introduce themselves to Resident #28 in a calm and reassuring manner. Additionally, staff failed to make redirection attempts with items or activities that were care planned.</p> <p>During an interview with RN #5 on 11/14/12 at 2:10 P.M., it was indicated typical behaviors were exhibited, earlier that day, by Resident #28. He indicated she</p>		<p>review 3 of the care plans of residents with a diagnosis of dementia and having behaviors weekly x 4 weeks, then 3 bi-weekly, then monthly until 95% compliance achieved. SSD will review 3 care plans of residents with PRN anti anxiety medications weekly x 4 weeks, then 3 bi-weekly x 4 weeks, then monthly until 95% compliance achieved. Any negative trends or patterns will be presented to PI monthly for review and or recommendations.</p>		

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	<p>counts, "5,6,7," , continually. Additionally, RN #5 indicated Resident #28 likes to read and reads well.</p> <p>Activity notes, dated 4/19/12, indicated Resident #28 "loves to look at magazines, loves pictures of birds, dogs, cat, babies. She is of Catholic faith. Loves to sit outside on porch."</p> <p>LPN #6 indicated, during an interview on 11/15/12 at 2:25 P.M., when Resident #28 gets anxious and talkative, in order to redirect her, give her magazines or a book. She especially likes magazines with dogs or birds. Or staff can write words or sentences on a paper and she can read them, out loud. LPN #6 continued to indicate that Resident #28 liked to talk and count repetitively. Counting, aloud, "5,6,7", was a normal behavior.</p> <p>On 11/19/12 at 3:31 P.M. the Activity Director (AD) indicated, during an interview, Resident #28 went to coffee hour and current events every morning. On Monday, Wednesday, and Friday mornings, Resident #28 went to small group discussion for lower cognitive functioning residents. She enjoys musical events, also. The AD indicated when Resident #28</p>						

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	<p>displays anxious, confused, and fearful behavior, staff were supposed to redirect her and reorient her to reality.</p> <p>During an interview on 11/20/12 at 9:30 A.M. with the Director of Nursing (DON), she indicated Resident #28 was not able to be reoriented or educated due to the dementia diagnosis. She indicated these interventions/approaches are inappropriate, as indicated on Resident #28's care plans.</p> <p>2. According to the November 2012 Physician's Order Recap, reviewed on 11/19/2012 at 9:10am, Resident #80 had an order for Lorazepam (anti-anxiety medication) 0.5 mg prn (as needed). According to Resident #80's November 2012 Medication Administration Record, the resident received the Lorazepam in November 2012 on the following dates 1, 3, 6, 8,12, and twice on the 14th of November.</p> <p>Review of Resident #80's Care Plan, dated 9/5/12, found the Care Plan did not contain non-pharmacological interventions to address the need that required the use of Lorazepam. Interview with the Social Service Director on 11/19/12 at 3:30pm, indicated no non-pharmacological</p>						

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	<p>interventions were developed to address the reason for the use of the medication.</p> <p>3.1-35(b)(1)</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide oral care and placement of splints in accordance with the care plan, for 1 of 20 residents reviewed for care plans. (Resident #20)</p> <p>Findings include:</p> <p>During an observation of Resident #20 on 11/13/12 at 12:05 P.M., Resident #20 was lying in a Broda chair with head of the chair up about 30 degrees. Her lips were dry in appearance and had a few dry flakes attached to her lips.</p> <p>The resident's clinical record was reviewed on 11/14/12 at 11 A.M. Resident #20's diagnoses included, but were not limited to, traumatic brain injury, contractures, seizures, and coronary artery disease.</p> <p>In an observation on 11/14/12 at 11:15 A.M., the resident was noted to have light brown liquid substance on her lips and also did not have her contracture braces on at this time.</p>	F0282	<p>F282</p> <p>1. Corrective action for resident affected by alleged deficient practice: Resident 20 was assessed for any adverse reaction related to oral status and decline in range of motion r/t splint and brace placement with nonnegative outcomes by nursing staff. Oral care was performed immediately and her splints were placed on her bilateral hands as plan of care stated. Her plan of care was updated to state she is to receive oral care at least BID and PRN and her care guides were updated as well.</p> <p>2. Corrective action</p>	12/20/2012			

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	<p>During an observation of the resident on 11/15/12 at 10 A.M., the resident did not have her contracture braces on at this time, and her lips were dry in appearance.</p> <p>The resident's Treatment Administration Record (TAR) for November 2012 indicated the resident was to have bilateral splints on during day and off at night. According to the TAR, Resident #20 gets showers on Monday and Friday on the 6-2 shift.</p> <p>In an interview with CNA #11 on 11/15/12 at 10:15 A.M., she indicated they provide oral care when they provide care to the resident about every 2 hours. The CNA indicated they ensure she has her splints on daily, when they clean her hands and feet. She also indicated the resident's head should be elevated at 45 degrees, and they turn her every 2 hours.</p> <p>The care plan, dated 7/27/12, indicated the nursing staff are to provide range of motion to bilateral (both) hands, splint placement daily, and observe for open areas prior to splint application. It also indicated the resident should have oral care every</p>		<p>taken for the residents that have the potential to be affected by the alleged deficient practice:</p> <p>Residents that are dependent on staff for oral care and residents who have orders for splint/brace placement will have their care plans, care guides, and treatment records reviewed by nursing administration to assure appropriate interventions are in place for oral care and splint placement by date of compliance.</p> <p>3. Measures/Systems put in place to assure alleged non deficient practice does not re occur:</p> <p>The SDC/Designee will in service nursing in relation to policy and procedure for providing ADLS including providing oral</p>	

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	hour. 3.1-35(g)(2)		care and placing splints on residents by date of compliance. PRN Nurses and aides will be in serviced prior to first scheduled shift. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The SDC/Designee will observe care on 3 residents to ensure oral care and splint placement is validated weekly x 4 weeks, then bi weekly x 4 weeks, then monthly until 95% compliance is achieved. Negative trends or patterns will be reviewed in PI monthly for review and or recommendations.		

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure residents received activities of daily living assistance for 2 of 3 residents reviewed for activities of daily living of 5 who met the criteria for activities of daily living. (Residents #20 and Resident # 30)</p> <p>Findings include:</p> <p>1. During an observation of Resident #20 on 11/13/12 at 12:05 P.M., Resident #20 was lying in a Broda chair with head of the chair up about 30 degrees. Her lips were dry in appearance and had a few dry flakes attached to her lips.</p> <p>The resident's clinical record was reviewed on 11/14/12 at 11 A.M. Resident #20's diagnoses included, but were not limited to, traumatic brain injury, contractures, seizures, and coronary artery disease.</p> <p>In an observation on 11/14/12 at 11:15 A.M., the resident was noted to</p>	F0312	<p>F312 1. Corrective action for residents affected by alleged deficient practice: Resident 20 was assessed for any negative outcome r/t oral status and splints by nursing staff and none was noted. Resident 30 was assessed for any negative outcome related to matted eyelashes by nursing staff and none was noted. Resident 20 had oral care performed, splints replaced, and resident 30 had her eyes cleansed. 2. Corrective action taken for those</p>	12/20/2012	

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	<p>have light brown liquid substance on her lips and also did not have her contracture braces on at this time.</p> <p>During an observation of the resident on 11/15/12 at 10 A.M., the resident did not have her contracture braces on at this time, and her lips were dry in appearance.</p> <p>The resident's Treatment Administration Record (TAR) for November 2012 indicated the resident was to have bilateral splints on during day and off at night. According to the TAR, Resident #20 gets showers on Monday and Friday on the 6-2 shift.</p> <p>In an interview with CNA #11 on 11/15/12 at 10:15 A.M., she indicated they provide oral care when they provide care to the resident about every 2 hours. The CNA indicated they ensure she has her splints on daily, when they clean her hands and feet. She also indicated the resident's head should be elevated at 45 degrees, and they turn her every 2 hours.</p> <p>The care plan, dated 7/27/12, indicated the nursing staff are to provide range of motion to bilateral (both) hands, splint placement daily,</p>		<p>residents who have the potential to be affected: Dependent residents have the potential to be affected therefore rounds were completed by nursing administration on Nov 30 th , 2012 and no other issues were determined related to adl care provided for dependent residents.</p> <p>3. Measures/Systems put in place to assure alleged deficient practice does not re occur: SDC/Designee will in service Nurses and aides on policy and procedure for performing activities of daily living and providing care and hygiene for dependent residents by date of compliance. PRN nurses and aides will be</p>		

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	<p>and observe for open areas prior to splint application. It also indicated the resident should have oral care every hour.</p> <p>2. The clinical record for Resident #30 was reviewed on 11/15/12 at 9:30 AM. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, anxiety, and chronic obstructive pulmonary disease.</p> <p>During an observation on 11/13/12 at 2:45 P.M., the resident's eyes were matted and crusty on the eyelashes.</p> <p>During an observation of Resident # 30 on 11/16/12 at 2:25 PM, the resident's eyelashes were matted.</p> <p>The care plan for Resident #30, dated 10/4/12, indicated she needed assistance with her activities of daily living, including hygiene.</p> <p>3.1-38(a)(3)</p>		<p>in serviced prior to first scheduled shift. The nursing staff directly involved with these residents on the particular dates quoted has been educated by the SDC.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The SDC/Designee will observe care on 3 dependent residents weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly until 95% compliance is achieved. Negative results will be presented to PI monthly for trends or patterns for further review and or recommendations.</p>		

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and observation, the facility failed for 1 of 3 residents reviewed for falls of 4 who met the criteria for accidents (#114) to implement care plan interventions designed to prevent a fall for a resident assessed at being at risk for falls.</p> <p>Findings include:</p> <p>Review on 11/20/12 at 8:40am of Resident #114's Minimum Data Set (MDS) assessment information, dated 11/1/2012, indicated the resident required extensive assist with one person when transferring and walking in the room. The MDS also indicated the resident had a prior history of falls in the month before admission in September 2012. Review of the Resident #114's care plan, dated 9/25/12, indicated an alarm was to be used at all times when in bed and when in a wheelchair due to a risk of falls.</p> <p>During observation 11/15/12 at</p>	F0323	<p>F323</p> <p>1. Corrective action for resident affected for the alleged deficient practice: Resident # 114 was observed by the Assistant Director of Nursing and noted to have his alarm in place. Staff involved in resident # 114 with fall on 11/6/12 was educated on safety. No injury resulted from fall.</p> <p>2. Corrective actions for residents who have the potential to be affected by the alleged practice: Residents with alarms have the potential to be affected therefore the ADON performed an audit</p>	12/20/2012	

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	<p>3:05pm, Resident #114 ambulated slowly with a rolling walker with therapy staff in the hallway. Staff remained very close for protection but not touching him throughout observation.</p> <p>Review of an 11/7/12 Incident Follow-up and Recommendation investigation report, on 11/20/12 at 8:45am, indicated Resident #114 sustained a fall on 11/6/12. The report indicated facility staff were re-inserviced regarding not leaving the resident unattended without initiating a chair alarm, as the investigation determined staff providing care had left the resident unattended and had not initiated the use of an alarm the resident was supposed to be using when in a wheelchair.</p> <p>3.1-45(a)(2)</p>		<p>on residents with alarms and found no other alarms not in place on (date). The ADON/Designee will audit and validate orders of alarms being on care plan, care guides, and treatment sheets by date of compliance.</p> <p>3. Measures/Systems put in place to assure alleged deficient practice does not re occur: The Assistant Director of Nursing/Designee will in service nurses and aides on safety interventions including alarms and the responsibility of the nursing staff to assure compliance by 12/20/2012. PRN nurses and aides will be in serviced prior to first scheduled shift.</p> <p>4. Corrective actions will be monitored to</p>		

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			ensure the alleged deficient practice does not re occur by: Nursing Administration will validate alarm placement on 10 residents weekly x 4 weeks, then bi weekly x 4 weeks, then monthly until 95% compliance is achieved. Negative patterns will be presented to PI monthly for review and recommendations.		

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was provided care and supervised during a nebulizer treatment for 1 of 2 nebulizer treatments observed. (Resident #30)</p> <p>Findings include:</p> <p>The clinical record for Resident #30 was reviewed on 11/15/12 at 9:30 A.M. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, anxiety, chronic obstructive pulmonary disease and cognitively impaired.</p> <p>In an interview with Resident # 30 on 11/16/12 at 2:25 P.M., she had a nebulizer mask around her neck that was turned on with nothing in it and she was alone in her room. At 2:45 PM the nebulizer machine was observed still turned on and</p>	F0328	<p>F328</p> <ol style="list-style-type: none"> Corrective action for resident affected by alleged deficient practice: Resident # 30 had a lung assessment performed with no negative outcomes. The nurse involved has been educated by the SDC prior to survey exit on the policy and procedure to follow when administering nebulizer treatments. Corrective action for residents who have the potential to be affected: Residents who receive 	12/20/2012

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	<p>running with nothing in it. LPN #3, as well as LPN #4, were seen walking up and down the hallway past the resident's room answering call lights and did not go in to turn it off.</p> <p>In an interview with the Corporate Consultant Nurse (CNC) on 11/20/12 at 9:30 AM, she indicated the nurse should be with the resident during the nebulizer treatment unless they are assessed for self-medication. At 9:38 AM she indicated if a resident is cognitively impaired, they would likely not perform a self-medication assessment. She stated the self-medication assessments are done by the MDS Nurse. The MDS nurse indicated on 11/20/12 at 9:40 AM that she was not aware of any medications that Resident #30 takes independently.</p> <p>An undated respiratory check off list for competencies for nurses was provided by the CNC on 11/20/12 at 1:10 P.M. and it indicated "...7. Patient Evaluation and Termination of Procedure: a. Monitors physiological parameters before, during , and after treatment...."</p> <p>3.1-47(a)(6)</p>		<p>Nebulizer treatments have the potential to be affected No other licensed nurses were noted to leave their residents while administering a nebulizer treatment during survey.</p> <p>3. Measures/Systemic changes put in place to assure alleged deficient practice does not re occur: The SDC/Designee will in-service and perform competency checks on licensed nursing to include the policy and procedure for administering nebulizer treatments by 12/20/2012. Prn nurses will be in serviced and have competency check prior to first scheduled shift.</p> <p>4. Corrective actions will be monitored to</p>				

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			<p>ensure alleged deficient practice does not re occur by:</p> <p>The SDC/Designee will perform 2 competencies weekly x 4 weeks, then 2 bi-weekly x 4 weeks, and then monthly until 95% compliance is achieved. Negative results will be presented to PI monthly for review and or recommendations.</p>	

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F0334 SS=E	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>				

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to educate or obtain consent regarding immunizations for 4 of 5 residents reviewed for immunizations. (Residents #16, 56, 83, 20)</p> <p>Findings include:</p> <p>According to the facility's policy "Influenza Vaccine, Pneumococcal Vaccine and Flu Outbreak Management," revised 12/06/07, the facility provides education to residents and/or representative regarding benefits, and side effects</p>	F0334	F334 1. Corrective actions for residents affected by alleged deficient practice: Residents # 16, 56, 83, and 20 have had their flu/PNU consents reviewed by nursing administration and now have the appropriate documentation required in the clinical record. The Power of Attorneys and	12/20/2012			

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	<p>or risks.</p> <p>According to Resident #56's record, reviewed 11/20/12 at 8:00am, Resident #56's Informed Consent for Influenza Vaccine was dated 11/1/12. It documented "Verbal permission given from (family member)." There was no evidence that the verbal consent was witnessed to ensure the person making the decision was educated and verified the consent was obtained after the information was presented. Resident #56's vaccine record indicated the flu vaccine was administered 11/1/12.</p> <p>According to Resident #16's record, reviewed 11/20/12 at 8:20am, the resident was admitted in August 2012. There was no documentation in Resident #16's record that flu or pneumococcal vaccines or education regarding the vaccines had been provided.</p> <p>During interview with the Staff Development Coordinator on 11/20/12 at 8:20am, the staff stated Resident #16 "refused to sign anything for me this year. She says she received it at the (previous facility). I'm still following up with the (previous facility)."</p> <p>Review of the resident's chart found no evidence in the record to indicate the facility had verified that vaccines</p>		<p>responsible parties of the above residents have been notified and educated on the risks versus benefits, side effects and the right to refuse.</p> <p>2. Corrective actions for the residents who have the potential to be affected: Residents have the potential to be affected therefore the SDC/designee completed an in house audit to assure no other residents have been affected by date of compliance.</p> <p>3. Measures/Systemic changes put in place to ensure the alleged deficient practice does not re occur: The SDC/Designee will in service licensed nursing on the policy and procedure on obtaining</p>		

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	<p>had been previously given.</p> <p>According to Resident #83's record, reviewed 11/20/12 at 8:25am, the resident received the flu vaccine on 10/19/12 and the Pneumococcal vaccine on 10/16/12. Resident #83's record contained no evidence the resident and/or family representative had been informed of risks versus benefits, side effects and the right to refuse the vaccine.</p> <p>According to Resident #20's record, reviewed 11/20/12 at 8:35am, Resident #20's Informed Consent for Influenza and Pneumococcal and Vaccines indicated "Verbal permission given from (family)." There was no evidence that the verbal consent was witnessed to ensure the person making the decision was educated regarding the risk versus benefits and the right to refuse treatment. The record indicated the pneumococcal vaccine was administered 10/16/12 and the flu vaccine administered 10/19/12.</p> <p>3.1-13(a)</p>		<p>consents including requiring 2 witnesses if there is a verbal consent, as well as assuring the family/resident have been educated on risks versus benefits, side effects, and the right to refuse the vaccine. Licensed Nursing staff will also be in serviced that they cannot administer the vaccine without the appropriate consents and documentation. In serving will be completed by 12/20/12. Prn nurses will be in serviced prior to first scheduled shift.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: SDC/Designee will audit 5 charts weekly x 90 days, then 10 charts monthly until 100% compliance is</p>		

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			achieved. Negative outcomes will be taken to PI monthly to be reviewed and or recommendations made.		

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to store clean coffee cups in a manner to prevent cross-contamination, handle drinking glasses in a sanitary manner during meal tray pass, and failed to follow proper handwashing techniques, during meal pass. This had the potential to affect 87 of 88 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>1. On 11/13/12 at 9:45 A.M., during the initial kitchen tour, ten coffee cups and 12 cereal bowls were stored on a rolling pallet with stacked crates, that had 4 wheels. Ten coffee cups and 12 cereal bowls were stored on the bottom crate. Three cereal bowls were observed on the top crate. The rolling crates were stored near the dishwasher area, right outside the dry storage area. The rolling pallet was 4 inches from the floor.</p> <p>During an interview with the Dietary</p>			F0371	<p>F371 1. Corrective actions for the residents affected by the alleged deficient practice: Clean dishes will be stored at least 6 inches of the ground to prevent cross contamination per regulation. Cited Staff was given direct education on the alleged deficient practice. 2. Corrective actions for those residents who have the potential to be affected: Residents have the potential to be affected therefore the appropriate education and in servicing will be provided to assure</p>		12/20/2012

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	Manager on 11/16/12 at 8:35 A.M., she indicated coffee cups and cereal bowls were stored in the crates and used by residents. She stated the kitchen was swept daily and the kitchen staff were expected to move the rolling crates out of the way when sweeping that area.		compliance with storage of clean utensils, handling drinking glasses in a sanitary manner during meal tray pass and following proper hand washing techniques during meal pass by date of compliance. 3. Measures/Systems put in place to assure alleged deficient practice does not re occur: Dietary Manager has in-serviced her kitchen staff on the proper storage of clean dishes to prevent cross contamination by date of compliance. The SDC/Designee will in service nursing staff on the policy and procedure of infection control practices and hand washing related to alleged cited deficient practice by 12/20/12. The		

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			<p>SDC/Designee will perform hand washing competency checks on nursing staff by date of compliance. Prn nursing staff will have in serving and competency checks completed prior to first scheduled shift.</p> <p>4. Corrective actions to be monitored to ensure the alleged deficient practice will not re occur by: The dietary manager will make rounds in the kitchen to assure compliance 5 times weekly x 4 weeks, then bi-weekly x 4 weeks, and monthly until 95% compliance achieved. Negative patterns/trends will be presented to PI monthly for review/recommendations . The ICN/designee will do hand washing</p>		

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	<p>2. During a meal observation on 11/13/12 at 12:24 P.M., on the Duncan hall, the Certified Nursing Aids were serving room trays. CNA #12 was observed touching 4 drinking glasses with fingertips around top. CNA # 13 was observed assisting a resident to reposition and then touched the top of a drinking glass without sanitizing or washing her hands.</p> <p>3. Review of the facility policy "A Guide to Infection Control" revised 5/1/2012 (reviewed 11/20/12 at 11:05am) indicated handwashing was to occur under running water for a minimum of 20 seconds using a rotary motion and friction.</p> <p>During observation of the assisted dining area on 11/13/2012 at 11:45am, CNAs #1 and #2 were</p>		<p>competencies 5 times weekly x 4 weeks, then bi weekly x 4 weeks then monthly until 95% compliance is achieved. Negative patterns/trends will be presented to PI monthly for review/recommendations</p>		

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	<p>observed to wash their hands for only 10 seconds and nine seconds respectively, using a sink in the dining area, before taking trays of food to resident tables and setting up the food for the meal. Also during the observation, CNA #1 moved a trash container near the tray holding area immediately prior to handwashing and then serving food.</p> <p>Interview with the ADON (Infection Control Coordinator) on 11/20/12 at 9:05am, regarding the handwashing policy, found that the ADON was unaware of the minimum 20 second requirement in the facility policy. The ADON also indicated that handwashing was monitored via observation 5 days a week to ensure staff are trained to prevent infections through proper handwashing. The ADON indicated the facility did not have a system which documented observations were systematically conducted to ensure staff implemented procedures to ensure proper sanitation and safe food handling.</p> <p>3.1-21(i)(3)</p>				

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F0425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to dispose of expired drugs for 1 of 2 medication rooms and for 2 of 11 insulin vials found in 1 of 6 medication carts on the Duncan hall.</p> <p>Findings include:</p> <p>The Director of Nursing was present during medication storage observation on 11/19/12 at 10:45 AM.</p> <p>In the Duncan hall medication room there were medications that were found under the counter in a basket</p>	F0425	<p>F425</p> <p>1. Corrective action for residents affected by alleged deficient practice: All expired medications were removed from the Duncan hall medication carts and Duncan Hall medication rooms by the DON. No negative outcomes were noted.</p> <p>2. Corrective action for residents who have the</p>	12/20/2012			

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	<p>which the Director of Nursing (DON) identified as their medication disposal basket. The expired medications were as follows: Bacitracin 8/30/12, Nystop 3/10/12, Mupirocin 3/21/12, Bacitracin zinc 9/17/12, Triamcinolone 3/23/12, Elidel 8/1/12, Nystatin 2/7/12, Nystop 3/12/12, Nystop 3/20/12.</p> <p>In an interview with LPN #3 on 11/19/12 at 11:00 A.M. she indicated she did not know those medications were there and did not know why they had not been discarded.</p> <p>In one of the two medication carts for Duncan Hall, two insulin vials were found to have expired and were over 28 days old after opening. One bottle was dated 10/1/12 and the other 10/15/12.</p> <p>In an interview with the DON on 11/19/12 at 11:10 AM, she indicated the insulins should have been disposed of.</p> <p>The policy for Medication Administration was provided on 11/19/12 and indicated insulin vials need to be discarded after 28 days after they have been opened.</p> <p>3.1-25(o)</p>		<p>potential to be affected: Residents have the potential to be affected therefore the medication carts and medication rooms were audited by nursing prior to survey exit and no other expired medications were found on medication carts or in medications rooms.</p> <p>3. Measures/Systems put into place to assure alleged deficient practice does not re occur: Licensed nurses will be in serviced by the SDC/Designee on policy for medication expiration and destruction by date of compliance. A schedule will be made by the DON for the nursing staff to audit their medication carts to assure no expired medications kept on medication carts and medications kept in</p>		

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			<p>medication rooms have been destroyed per facility policy.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: Nursing administration will audit medications rooms daily Monday through Friday for expired and discontinued medications x 4 weeks, and then bi-weekly x 4 weeks, then monthly until 95% compliance is achieved. Night shift nurses will audit medication carts weekly to assure no expired insulin's are on medication carts weekly x 90 days or until 95% compliance is achieved. Nursing administration will perform random audits on medication</p>		

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			<p>carts to ensure compliance. Negative patterns will be presented to PI monthly for review and or recommendations.</p>	

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview, observation and record review, the facility failed to</p>	F0441	F 441	12/20/2012			

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	<p>implement an infection control program monitoring staff handwashing, and failed to sanitize a glucometer between residents during a random observation of glucometer use for one resident (Resident #18).</p> <p>Findings include:</p> <p>1. During an observation of medication pass on 11/19/12 at 4:30 P.M., LPN #13 was not observed to sanitize a glucometer after use on Resident #18.</p> <p>An interview with the Director of Nursing (DON), on 11/19/12 at 5:00 P.M., indicated nurses were expected to sanitize glucometers after each use.</p>		<p>1. Corrective action for residents affected by alleged deficient practice: Resident # 18 has been observed for any negative outcomes and none have been noted in relation to infections. The resident has been informed the facility will in service licensed nursing on the appropriate sanitation of glucometers after each use. The Infection Control nurse initiated hand washing observations of nursing staff.</p> <p>2. Corrective action taken for residents having the potential to be affected: Residents have the potential to be affected. Competency checks were initiated for licensed nurses to assure proper sanitation was being performed on</p>		

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			<p>glucometers between uses by nursing administration on 11/20/12. The Infection Control Nurse initiated hand washing observations with documentation on 11/21/12 to ensure the facility is monitoring staff hand washing.</p> <p>3. Measures/Systems put in place to assure alleged deficient practice does not re occur: Licensed nursing will be in serviced on the policy and procedure for sanitizing glucometers between use and have competency checks completed by date of compliance by the SDC/Designee. PRN nurses will be in serviced and have competency checks prior to first scheduled shift. The ICN will be in serviced by the</p>	

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			<p>DON on the proper observations and documentation of hand washing and systems to ensure proper sanitation by date of compliance.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The SDC/Designee will perform competency checks on sanitizing glucometers on licensed nurses 3 times weekly x 4 weeks, then 3 times bi-weekly x 4 weeks, then 3 times monthly until 100% compliance is achieved. The ICN/Designee will perform 5 observations weekly for infection control practices to include hand washing on staff x 4 weeks, then 5 times bi-weekly, then 5</p>		

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	<p>2. Review of the facility's policy, "A Guide to Infection Control, revised 12/06/2007, indicated when monitoring for a flu outbreak, staff and resident awareness of handwashing needs to be encouraged and monitored.</p> <p>According to interview with the ADON (Infection Control Coordinator) on 11/20/12 at 9:05am., "Observation on the floor is key to surveillance...I'm observing for infection control practices 5 days a week." The ADON indicated the facility did not have a system which documented observations were systematically conducted to ensure staff implemented procedures to ensure proper sanitation.</p> <p>3.1-18(l) 3.1-18(b)(1)</p>		<p>times monthly until 95 % compliance is achieved. Negative patterns or trends will be presented to PI monthly for review and or recommendations.</p>		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE 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 interview and record review, the facility failed to ensure accurate documentation for 2 of 3 residents reviewed for weight loss in a sample of 6 who met the criteria for significant weight loss. (Residents #30 and 85)</p> <p>Findings include:</p> <p>1. The medical record of Resident #85 was reviewed on 11/19/12 at 9:30 A.M.</p> <p>A review of the residents weights for the months of September 3 to November 19, 2012 were as follows:</p> <table border="0"> <tr> <td>9/3/12</td> <td>116.3</td> </tr> <tr> <td>9/27/12</td> <td>122.5</td> </tr> <tr> <td>10/4/12</td> <td>118</td> </tr> </table>			9/3/12	116.3	9/27/12	122.5	10/4/12	118	F0514	<p>F514</p> <p>1. Corrective action for residents affected by alleged deficient practice: Resident # 85 and 30 were weighed by staff and an accurate weight was obtained and given to the Dietary manager to put into the clinical record.</p> <p>2. Corrective action for residents who have the potential to be affected: Residents have the potential to be affected therefore residents will</p>		12/20/2012
9/3/12	116.3												
9/27/12	122.5												
10/4/12	118												

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	<p>11/11/12 111.5 11/14/12 120.2 (reweigh) 11/19/12 115</p> <p>A Dietary note, dated for the month of October 2012, indicated Resident #85's weight was 120.4 pounds. BMI = 21.3 and consumed 77% of meals. No change to current diet. The weight of 120.4 pounds was not found on the monthly or weekly weight sheets.</p> <p>During an interview with the Director of Nursing, on 11/19/12 at 2:10 P.M., she indicated there has been a problem with getting accurate weights recorded. The Dietary Manager is responsible for logging the weights into the computer and reviewing the weights. The weights of 120.2 and 120.4 pounds were not correct.</p>		<p>have weights and clinical documentation reviewed for accuracy by date of compliance by dietary manager and nursing administration.</p> <p>3. Measures/Systems put in place to ensure the alleged deficient practice does not re occur: The SDC/Designee will in service nursing staff and the dietary manager on the policy and procedure for obtaining accurate weights by date of compliance. This is to include if and when a reweigh is required, when and how to weight residents to assure accuracy and weights are to be reviewed by DON and Dietary Manager prior to being entered into the clinical record.</p> <p>4. Corrective actions will be monitored to</p>		

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			<p>ensure the alleged deficient practice does not re occur by: The SDC/Designee will perform 3 competency checks on nursing staff in relation to obtaining weights accurately weekly x 4, and then bi-weekly x 4, then monthly until 95% compliance is achieved. The Registered Dietician will meet with the Dietary Manager and the DON to ensure weights are accurate prior to documenting in the clinical record weekly x 4, then bi-weekly x 4 weeks, then monthly until 95% accuracy is achieved. The dietary manager will audit 5 charts weekly x 4 weeks, then 5 charts bi weekly x 4 weeks, then monthly until 95% compliance is achieved to assure care plan, dietary</p>		

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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906			
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	<p>2. The clinical record for Resident #30 was reviewed on 11/15/12 at 9:30 A.M. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, anxiety, chronic obstructive pulmonary disease and cognitively impaired.</p> <p>The NAR (Nutritionally at Risk) notes indicated Resident# 30 has had significant weight loss in 30 days.</p> <p>The entries were as follows: 6-23-12- 99.0 7-9-12- 100.8 7-13-12- no weight 7-18-12- 99.6 7-24-12- no weight 8-1-12- 99.8 8-9-12- 98.8 8-15-12 - 95 8-23-12 - 98.8</p>		<p>notes, Registered dietician notes, and Nutritionally at Risk notes all validate accurate documentation of weights. Negative trends and patterns will be presented to PI monthly for review and or recommendations.</p>				

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	<p>8-29-12 - 104.4 9-5-12 - no weight 9-12-12- no weight 9-24-12 - 99.8 9-27-12- no weight 10-4-12 - 91.2 10-16-12 89.1 10-22-12- 100 reweight - 100.4 10-24-12 - 95.2 11-7-12 - 104.8 11-14-12 - 96.2</p> <p>The notes on the NAR indicated 7-24-12 request reweight. 8-15-12- request re-weight (nothing documented) 8-23-12- monitor weight one more week. 8-29-12 weight up 5.6 lbs questionable weight, continue for one more week. 9/5/12- request re-weight related to weight increase another 5 lbs. 10/4/12- weight obtained two times, significant weight loss in 30 days. 10-22-12- weight increase 11.4 pounds. Two weights obtained, questionable weight. 11-7-12- weight increase, doubt accuracy, Request reweight.</p> <p>In an interview on 11/19/12 at 2:30 PM, the Registered Dietician indicated she had followed Resident #30 in the last month. She indicated she discusses with</p>						

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	<p>family or resident if they think the weights are questionable. She indicated it has been a challenge with weights. She indicated the facility had their scales looked at for calibration. She indicated they are trying to obtain better record keeping with weekly weights and a standardized weekly weight sheet in July and August.</p> <p>3.1-50(a)(2)</p>						