STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155718		02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NORTHVIEW CARE CENTER	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This survey included a State Residential Survey. Survey dates: February 17, 18, 19, 22, 23 and 24. Facility number: 000562 Provider number: 155718 AIM number: 100267150 Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 20 Medicaid: 35 Other: 34 Total: 89 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on March 1, 2016.	F 0000	This Plan of Correction constitutes the written allegation of compliance for deficiencies cited However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly The Plan of Correction is submitted to meet requirements established by state and federal law	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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F 0279 SS=D Bldg. 00	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. 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. 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).			
	Based on observation, interview, and record review, the facility failed to ensure careplans were developed to ensure continuity of care for a resident requiring adaptive equipment to maintain proper position in his wheelchair. (Resident #77) Findings include: On 2/18/16 at 8:37 a.m., Resident #77 was observed in his wheelchair in the Rosewood lounge. He was slouched down and leaning to the right in the wheelchair and his feet were dangling	F 0279	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #77 has his foot buddy and the knee adductor on while up in his wheelchair The need for this has been added to the assignment sheet for easy access for C.N.A's. The adductor is actually attached to the wheelchair. The care plan for these adaptive equipment items has been updated HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME	03/09/2016

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	above the foot pedals. On 2/18/16 at 10:44 a.m. Resident #77 was observed in his wheelchair in the hallway, being propelled by a staff member. He was slouched down and leaning to the right in the wheelchair and his feet were dangling above the foot pedals. On 2/18/16 at 12:59 p.m., Resident #77 was observed in his wheelchair in the Rosewood lounge. His feet were dangling above the foot pedals. On 2/19/16 at 10:15 a.m., Resident #77 was observed in his wheelchair in the Rosewood lounge. He was slouched down and leaning to the right in the wheelchair and his feet were dangling above the foot pedals. On 2/19/16 at 12:48 p.m., Resident #77 was observed in his wheelchair in the hallway, being propelled by a staff member. His feet were dangling above the foot pedals. On 2/22/16 at 8:41 a.m., Resident #77 was observed in the main dining room for breakfast. He was leaning over the right side of wheelchair and his feet were dangling above the foot pedals.		DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: Any resident who has orders for adaptive equipment could be affected An audit has been completed on all residents to assure that if there is an order for adaptive equipment it has been care planned and added to the assignment sheets. The Therapy department will give all new orders to the nurse on that hall and go over any new adaptive equipment orders during the daily huddle to assure that we are communicating Once the order is given to the nurse, a care plan and the C.N.A assignment sheet will be updated. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Unit Managers will be auditing the adaptive equipment on a 3 X's weekly to assure that all adaptive equipment has been care planned and that the information is added to the C.N.A. assignment sheets. A discussion of any new adaptive equipment will take place in the morning huddles with follow up being completed by the Unit Managers to assure the info is put on the care plan and the C.N.A assignment sheet. The Therapy department will give all new orders to the nurse on that hall and go over any new adaptive	

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	On 2/22/16 at 9:26 a.m., Resident #77 was observed in his wheelchair in the Rosewood lounge. He was leaning to the right in the wheelchair. His right foot dangled above the foot pedals. His left leg was pulled upward with his shoe off and laying on floor. On 2/22/16 at 10:35 a.m., Resident #77 remained in his wheelchair in the Rosewood lounge. He was leaning to the right in the wheelchair. His right foot continued to dangle above the foot pedals. His left leg was still pulled upward with his shoe off and laying on floor. On 2/22/16 at 11:49 a.m., Resident #77 was observed in his wheelchair in the main dining room with a foot buddy cushion covering the foot pedals. On 2/22/16 at 2:26 p.m., Resident #77 was observed in his wheelchair in his room. His feet were dangling above the foot pedals. There was no foot buddy cushion on his foot pedals. On 2/23/16 at 8:21 a.m., Resident #77 was observed in his wheelchair in the main dining room. There was a knee adductor in place to the right side of his wheelchair. There was no foot buddy cushion in place and his feet were		equipment orders during the daily huddle to assure that we are communicating Once the order is given to the nurse, a care plan and the C.N.A assignment sheet will be updated. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: A new Performance Improvement Plan (PIP) has been created and the results of the audit will be discussed during the monthly QA meetings held with the QA committee as well as the quarterly meetings held with the Medical Director and the Pharmacy Consultant These audits will continue until 100% compliance has been achieved and maintained for six (6) months. At that time the QA committee will discuss whether to continue or discontinue the audits.	

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	dangling above the foot pedals. On 2/23/16 at 9:21 a.m., Resident #77 was observed in the Rosewood lounge. There was a knee adductor in place to the right side of his wheelchair. There was no foot buddy cushion in place and his feet were dangling above the foot pedals. On 2/23/16 at 12:57 p.m., Resident #77 was observed in the Rosewood lounge. There was a knee adductor in place to the right side of his wheelchair. There was a foot buddy cushion in place to the wheelchair. On 2/24/16 at 9:08 a.m., Resident #77 was observed in the Rosewood lounge. There was a knee adductor in place to the right side of his wheelchair. There was no foot buddy cushion in place and his feet were dangling above the foot pedals. Review of Resident #77's clinical record began on 2/18/16 at 9:52 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, decreased mobility, decreased ADL function, and history of falls. Resident #77 had a current, 12/4/15, quarterly MDS (Minimum Data Set) assessment which indicated the resident was severely cognitively impaired and			

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	required extensive assist with ADLs and mobility. Review of an "Occupational Therapy PT Evaluation & Plan of Treatment", dated 12/8/15, indicated Resident #77 required frequent repositioning multiple times in less than 30 minutes to prevent falling out of his wheelchair. Review of an "Occupational Therapy Discharge Summary", dated 1/1/16, indicated Resident #77 required a right knee adductor and foot buddy for proper positioning in his wheelchair. On 2/23/16 at 9:27 a.m., during an interview with CNA #15 and CNA #16, they indicated they were not sure what adaptive equipment Resident #77 was supposed to have on his wheelchair. CNA #15 indicated the resident's wheelchair had a foot buddy the previous day, but thought it might have broken, so it could not be used. On 2/23/16 at 9:35 a.m., CNA #15 indicated adaptive equipment was usually listed on the CNA assignment sheets. She indicated the assignment sheet listed only a high-back wheelchair. On 2/23/16 at 9:42 a.m., RN #13 indicated adaptive equipment was			

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	sometimes listed on the resident's treatment sheets. During an interview on 2/24/16 at 12:31 p.m., the ADON and the Dogwood Unit Manager indicated Resident #77's adaptive equipment should have been careplanned and added to the CNA assignment sheets to ensure consistency of use. They indicated that this had not occurred. During an interview with Occupational Therapist #17 on 2/24/16 at 1:07 p.m., she indicated the ordered adaptive equipment should have been carried forward for the nursing staff to implement. She indicated the nursing staff would have been inserviced on the use of the new adaptive equipment. She was not able to locate the inservice log by the end of the survey. 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the physician's orders and care plan	F 0282	NOTE OF CONCERN. THIS TAG WAS NOT MENTIONED AT ALL DURING THE EXIT.	03/09/2016

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	interventions for 1 of 28 residents whose care plans were reviewed. (Resident's #118) Findings include: A review of the medical record for Resident #118 began on 02/18/2016 at 2:46 p.m. The diagnoses included but were not limited to, decreased mobility and ADL [activities of daily living] d/t [due to] fall with left hip fracture, s/p [status post] IM [intramedullary nail] nailing, Alzheimer's, dementia and degenerative disk disease. The most recent MDS (Minimum Data Set) assessment indicated Resident #118 was severely cognitively impaired. During an interview with a family member of Resident #118, on 02/18/2016 at 1:07 p.m., she indicated that Resident #118 was at the facility for rehabilitation and recovery after a fall at his home. She indicated that, two days prior to this interview, Resident #118 fell while trying to get out of his bed. As a result of that fall, the resident needed to have another surgery on 2/19/2016. She indicated that Resident #118 was supposed to have had an alarm on to alert staff if he was trying to get out of bed on his own. She then indicated Resident #118 did not have an alarm on at the time of the fall.		WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident 118 had his ORIF surgically repaired on 2/19/16 He returned to the facility on 2/22/16 and is currently doing fine. His condition is stable. He does have metastatic cancer from prostrate to bladder and will undergo further surgery on 3/23/16. He is located in a room closer to the nurses station and he has a personal alarm on at all times HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: Any resident who is at risk for falls could be affected. All residents who are at risk for falls have been evaluated to determine the need for personal alarms. A new fall prevention program has been implemented This program is a focused and intentional integration of all falls. A 24 hour report mechanism, generated through the EMR is being implemented to facilitate communication amongst staff regarding residents and their needs WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT	

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	During an interview with Unit Manager #1 on 02/23/2016 at 11:04 a.m., she indicated that Resident #118 lived at this facility then discharged to home where he fell and broke his hip. She indicated Resident #118 then returned to this facility for rehabilitation after hip surgery. She indicated Resident #118 then fell again on 2/16/2016 and was sent out to the emergency room for a cat scan (CT) and X-rays. Unit Manager #1 then indicated that the hospital called and indicated the results of both tests were negative. The resident returned to the facility. When he went to the regularly scheduled orthopedic appointment he was scheduled for, the orthopedic office found the "failed repair." Unit Manager #1 indicated the alarms that were supposed to be in place were not and that Resident #118 was wearing regular socks not "gripper socks." Unit Manager #118 indicated Resident #118 had increased confusion during the time prior to the fall and did not offer any other indications as to why Resident #118 fell. During an interview with PTA (Physical Therapy Assistant) #2 on 2/24/2016 at 10:25 a.m., she indicated that Resident #118 was "definitely a fall risk" prior to his fall on 2/16/2016. She indicated that Resident was also "very out of it" and		PRACTICE DOES NOT RECUR: A new fall prevention program has been implemented This program is a focused and intentional integration of all falls. A 24 hour report mechanism, generated through the EMR is being implemented to facilitate communication amongst staff regarding residents and their needs An audit tool has been developed to assure compliance Walking rounds will be completed by the nurses on every shift to monitor and assure that all orders for personal alarms are accurate and in place. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The results of the audit tool will be discussed during the monthly QA committee meeting This audit tool will continue until 100% compliance has been reached for a minimum of 6 months. At that time, the QA committee will decide the need to continue or discontinue the audit.	

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	"lethargic" in the days prior to the fall. During an interview with COTA #1 (Certified Occupational Therapy Assistant) on 2/24/2016 at 10:32 a.m., he indicated that he had worked with Resident #118 prior to the fall on 2/16/2016. He indicated that although Resident #118 was doing better with Occupational Therapy at the time of the fall, he was still a fall risk. COTA #1 indicated Resident #118 was "out of it" due to the anesthesia from the previous surgery and the daily medication the resident was taking. During an interview with LPN #10 on 2/24/2016 at 12:54 p.m., she indicated that Resident #118 was a fall risk. She indicated his risk factors, prior to the fall on 2/16/2016, included confusion, previous hip repair and the resident not being full weight bearing. LPN #10 indicated the interventions added after the fall were alarms and 15 minute checks. LPN #10 indicated that Resident #118 had a problem with anesthesia indicated by lethargy and "being out of it." The physician orders, signed on 2/8/2016, were provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m., indicated "PBA [personal body alarm] on at all times to			

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	alert staff of unassisted transfers. Confirm placement and function q [every] shift. Bed alarm on when in bed to alert staff of unassisted transfer, confirm placement and function q shift. F/U [follow up] [Physician Name] 2/17/2016 at 10:00 a.m." A document titled "FALL FOLLOW UP" was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m. It indicated Resident #118 had a fall on 2/16/2016 at 6:45 p.m. The incident description indicated LPN #11 found Resident #118 next to his bed laying on his back parallel to the bed. Resident #118 was noted to be "unable to move his left lower extremity" and was sent to the emergency room as a precaution. Predisposing Physiological factors were listed as "confused, gait imbalance, recent change in cognition, recent illness, weakness/fainted, impaired memory." Predisposing Situational Factors were listed as "improper footwear, recent room change and side rails up." A document titled "FSI- FALL SCENE INVESTIGATION REPORT" was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m. It indicated Resident #118 had an unobserved fall on 2/16/2016 at 6:45 p.m. in room 310. The investigation indicated Resident #118			

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	was resting alone in bed just prior to the fall. The investigation then indicated Resident #118 was unable to verbalize actions at this time as to what he was doing just prior to the fall. The investigation indicated the resident was wearing socks, had no assistive devices and there was no alarm being used at the time of the fall. Root causes of the fall was listed as alarm, footwear, medical status/physical condition/diagnosis and mood or mental status. The fall team meeting notes indicated the alarms did not come with Resident #118 when he transferred from Rose Wood Hall and had no order for them in Point Click Care. The order for the alarm was on the paper physician orders for Resident #118. A copy of the physician progress note for Resident #118, dated 2/17/2016, was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m. It indicated "Failed ORIF [open reduction internal fixation] left hip from surgery by [Doctor Name] due to fall. A note signed by the ADON, dated 2/17/2016, was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m., indicated the following "Resident returned from [Name of Orthopedic Physician's Office] with surgery schedule to change hardware to Lt [left] hip r/t			

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	[related to] failed ORIF. Daughter reported to nurse that resident's hip was 'broken' and this writer called for clarification. Spoke with PA/NP [Physician Assistant/Nurse Practioner] [PA/NP Name] who assessed resident at appointment. [PA/NP Name] stated that resident's hardware to hip was displaced and no longer in alignment and hardware would have to be replaced. When this writer inquired as to XRAY report from hospital stating "fractures" [PA/NP Name] stated that fractures that were seen on X-rays were the fractures that occurred with fall which required surgery in the first place. Fractures would not be healed as yet." The Morris Fall Risk Assessment document for Resident #118 was dated 2/8/2016. It was provided by Unit Manager #1 on 2/23/2016 at 2:57 p.m., and indicated he was at high risk for falling and to implement high risk fall prevention interventions. The care plan for Resident #118 was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m. It indicated the care plan was initiated on 2/11/2016 and that Resident #118 was high risk for falls related to being unaware of safety needs, confusion, deconditioning and gait/ balance problems. The goal was that			

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	Resident #118 would be free of falls with injury through the review date. Interventions included but were not limited to "The resident uses: PBA [Personal Body Alarm]/ bed electronic alarm. Ensure the device is in place as needed." On 2/24/2016 at 12:10 p.m., the DON provided a document on hospital letter head that indicated the following "Community Northview Care Center does not have a specific policy that states physician's orders will be followed. The Nursing Dept. [Department] does however operate on the basis of following physician orders to provide medical care to our residents." 3.1-35(g)(2)			
F 0312 SS=D Bldg. 00	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 place adaptive equipment to maintain positioning for 1 of 28 residents reviewed for ADL care (Resident #77).	F 0312	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #77 has his foot buddy and the knee adductor on while	03/09/2016

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	Findings include: On 2/18/16 at 8:37 a.m., Resident #77 was observed sleeping in his wheelchair in the Dogwood lounge. He was slouched down and leaning to the right in the wheelchair and his feet were dangling above the foot pedals. On 2/18/16 at 10:44 a.m. Resident #77 was observed in his wheelchair in the hallway, being propelled by a staff member. He was slouched down and leaning to the right in the wheelchair and his feet were dangling above the foot pedals. On 2/18/16 at 12:59 p.m., Resident #77 was observed in his wheelchair in the Dogwood lounge. His feet were dangling above the foot pedals. On 2/19/16 at 10:15 a.m., Resident #77 was observed in his wheelchair in the Dogwood lounge. He was slouched down and leaning to the right in the wheelchair and his feet were dangling above the foot pedals. On 2/19/16 at 12:48 p.m., Resident #77 was observed in his wheelchair in the hallway, being propelled by a staff member. His feet were dangling above the foot pedals.		up in his wheelchair The need for this has been added to the assignment sheet for easy access for C.N.A's. The adductor is actually attached to the wheelchair. The care plan for these adaptive equipment items has been updated HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: Any resident who has orders for adaptive equipment could be affected An audit has been completed on all residents to assure that if there is an order for adaptive equipment it has been care planned and added to the assignment sheets. The Therapy department will give all new orders to the nurse on that hall and go over any new adaptive equipment orders during the daily huddle to assure that we are communicating Once the order is given to the nurse, a care plan and the C.N.A assignment sheet will be updated. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Unit Managers will be auditing the adaptive equipment on a 3 X's weekly to assure that all adaptive equipment has been care planned and that the information is added to the C.N.A.	

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	On 2/22/16 at 8:41 a.m., Resident #77 was observed in the main dining room for breakfast. He was leaning over the right side of wheelchair and his feet were dangling above the foot pedals. On 2/22/16 at 9:26 a.m., Resident #77 was observed in his wheelchair in the Dogwood lounge. He was leaning to the right in the wheelchair. His right foot dangled above the foot pedals. His left leg was pulled upward with his shoe off and laying on floor. On 2/22/16 at 10:35 a.m., Resident #77 remained in his wheelchair in the Dogwood lounge. He was leaning to the right in the wheelchair. His right foot dangled above the foot pedals. His left leg was pulled upward with his shoe off and laying on floor. On 2/22/16 at 11:49 a.m., Resident #77 was observed in his wheelchair in the main dining room with a foot buddy cushion covering the foot pedals. On 2/22/16 at 2:26 p.m., Resident #77 was observed in his wheelchair in his room. His feet were dangling above the foot pedals. There was no foot buddy cushion on his foot pedals.		assignment sheets. A discussion of any new adaptive equipment will take place in the morning huddles with follow up being completed by the Unit Managers to assure the info is put on the care plan and the C.N.A assignment sheet. The Therapy department will give all new orders to the nurse on that hall and go over any new adaptive equipment orders during the daily huddle to assure that we are communicating Once the order is given to the nurse, a care plan and the C.N.A assignment sheet will be updated. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: A new Performance Improvement Plan (PIP) has been created and the results of the audit will be discussed during the monthly QA meetings held with the QA committee as well as the quarterly meetings held with the Medical Director and the Pharmacy Consultant These audits will continue until 100% compliance has been achieved and maintained for six (6) months. At that time the QA committee will discuss whether to continue or discontinue the audits.	

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	On 2/23/16 at 8:21 a.m., Resident #77 was observed in his wheelchair in the main dining room. There was a knee adductor in place to the right side of his wheelchair. There was no foot buddy cushion in place and his feet were dangling above the foot pedals. On 2/23/16 at 9:21 a.m., Resident #77 was observed in the Dogwood lounge. There was a knee adductor in place to the right side of his wheelchair. There was no foot buddy cushion in place and his feet were dangling above the foot pedals. On 2/23/16 at 12:57 p.m., Resident #77 was observed in the Dogwood lounge. There was a knee adductor in place to the right side of his wheelchair. There was a foot buddy cushion in place to the wheelchair. On 2/24/16 at 9:08 a.m., Resident #77 was observed in the Dogwood lounge. There was a knee adductor in place to the right side of his wheelchair. There was no foot buddy cushion in place and his feet were dangling above the foot pedals. Review of Resident #77's clinical record began on 2/18/16 at 9:52 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, decreased mobility, decreased ADL function, and history of			

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	falls. Resident #77 had a current, 12/4/15 quarterly MDS (Minimum Data Set) assessment which indicated the resident was severely cognitively impaired and required extensive assist with ADLs and mobility. Review of an "Occupational Therapy PT Evaluation & Plan of Treatment", dated 12/8/15, indicated Resident #77 required frequent repositioning multiple times in less than 30 minutes to prevent falling out of his wheelchair. Review of an "Occupational Therapy Discharge Summary", dated 1/1/16, indicated Resident #77 required a right knee adductor and foot buddy for proper positioning in his wheelchair. On 2/23/16 at 9:27 a.m., during an interview with CNA #15 and CNA #16, they indicated they were not sure what adaptive equipment Resident #77 was supposed to have on his wheelchair. CNA #15 indicated the resident's wheelchair had a foot buddy the previous day, but thought it might have broken, so it could not be used. On 2/23/16 at 9:35 a.m., CNA #15 indicated adaptive equipment was usually			

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	listed on the CNA assignment sheets. She indicated the assignment sheet listed only a high-back wheelchair. On 2/23/16 at 9:42 a.m., RN #13 indicated adaptive equipment was sometimes listed on the resident's treatment sheets. During an interview on 2/24/16 at 12:31 p.m., the ADON and the Dogwood Unit Manager indicated Resident #77's adaptive equipment should have been careplanned and added to the CNA assignment sheets to ensure consistency of use. They indicated that this had not occurred. During an interview with Occupational Therapist #17 on 2/24/16 at 1:07 p.m., she indicated the ordered adaptive equipment should have been carried forward for the nursing staff to implement. She indicated the nursing staff would have been inserviced on the use of the new adaptive equipment. She was not able to locate the inservice log by the end of the survey. 3.1- 38(a)(3)(A)			
F 0323	483.25(h)			

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SS=G Bldg. 00	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 interview and record review, the facility failed to ensure a resident was free from falls during his stay at the facility for one of three residents reviewed for accidents. This deficit practice resulted in the ORIF [open reduction and internal fixation] that requiring a repeat surgery due to a fall at the facility. (Resident #118) Findings include: A review of the medical record for Resident #118 began on 02/18/2016 at 2:46 p.m., indicated the diagnoses included but were not limited to decreased mobility and ADL [activities of daily living] d/t (due to) fall with left hip fracture, s/p (status post) IM (intramedullary nail) nailing, Alzheimer's, dementia and degenerative disk disease. The most recent MDS (Minimum Data Set) assessment indicated Resident #118 was severely cognitively impaired. During an interview with a family member of Resident #118 on 02/18/2016	F 0323	WE INTEND TO REQUEST AN IDR FOR THIS TAG BASED ON THE PRIOR CONDITION OF THE RESIDENT AND THE LACK OF PROOF THAT THE ORIF FAILED DUE TO THE FALL. AS A MATTER OF FACT, THERE IS EVIDENCE THAT THE DAY BEFORE THE FALL THE RESIDENT WAS NOT ABLE TO BEAR WEIGHT ON EITHER LEG ACCORDING TO THERAPY WHO HAD BEEN WORKING WITH HIM EXTENSIVELY, THEREBY INDICATING THAT THE ORIF MIGHT HAVE FAILED PRIOR TO THE FALL. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident 118 had his ORIF surgically repaired on 2/19/16 He returned to the facility on 2/22/16 and is currently doing fine. His condition is stable. He does have metastatic cancer from prostrate to bladder and will undergo further surgery on 3/23/16. He is located in a room closer to the nurses station and he has a personal alarm on at all times HOW OTHER RESIDENTS	03/09/2016

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	at 1:07 p.m., she indicated that Resident #118 was at the facility for rehabilitation and recovery after a fall at his home. She indicated that, two days prior to this interview, Resident #118 fell while trying to get out of his bed and as a result of that fall needed to have another surgery on 2/19/2016. She indicated that Resident #118 was supposed to have had an alarm on to alert staff if he was trying to get out of bed on his own. She then indicated Resident #118 did not have an alarm on at the time of the fall. During an interview with Unit Manager #1 on 02/23/2016 at 11:04 a.m., she indicated that Resident #118 lived at this facility then discharged to home where he fell and broke his hip. She indicated Resident #118 then returned to this facility for rehabilitation after hip surgery. She indicated Resident #118 then fell again on 2/16/2016 and was sent out to the emergency room for a cat scan (CT) and X-rays. Unit Manager #1 then indicated that the hospital called and indicated the results of both tests were negative. The resident returned to the facility however went to the regularly scheduled orthopedic appointment he was scheduled for where they found the "failed repair." Unit Manager #1 indicated the alarms that were supposed to be in place were not and that Resident		HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: Any resident who is at risk for falls could be affected. All residents who are at risk for falls have been evaluated to determine the need for personal alarms. A new fall prevention program has been implemented This program is a focused and intentional integration of all falls. A 24 hour report mechanism, generated through the EMR is being implemented to facilitate communication amongst staff regarding residents and their needs WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: A new fall prevention program has been implemented This program is a focused and intentional integration of all falls. A 24 hour report mechanism, generated through the EMR is being implemented to facilitate communication amongst staff regarding residents and their needs An audit tool has been developed to assure compliance Walking rounds will be completed by the nurses on every shift to monitor and assure that all orders for personal alarms are accurate and in place. HOW THE	

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	#118 was wearing regular socks not "gripper socks." Unit Manager #118 indicated Resident #118 had increased confusion during the time prior to the fall and did not offer any other indications as to why Resident #118 fell. During an interview with PTA (Physical Therapy Assistant) #2 on 2/24/2016 at 10:25 a.m., she indicated that Resident #118 was "definitely a fall risk" prior to his fall on 2/16/2016. She indicated that Resident was also "very out of it" and "lethargic" in the days prior to the fall. During an interview with COTA #1 (Certified Occupational Therapy Assistant) on 2/24/2016 at 10:32 a.m., he indicated that he had worked with Resident #118 prior to the fall on 2/16/2016. He indicated that although Resident #118 was doing better with Occupational Therapy at the time of the fall, he was still a fall risk. COTA #1 indicated Resident #118 was "out of it" due to the anesthesia from previous surgery and daily medication the resident was taking. During an interview with LPN #10 on 2/24/2016 at 12:54 p.m., she indicated that Resident #118 was a fall risk and his risk factors prior to the fall on 2/16/2016 included confusion, previous hip repair		CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The results of the audit tool will be discussed during the monthly QA committee meeting This audit tool will continue until 100% compliance has been reached for a minimum of 6 months. At that time, the QA committee will decide the need to continue or discontinue the audit.	

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	and the resident not being full weight bearing. LPN #10 indicated the interventions added after the fall were alarms and 15 minute checks. LPN #10 indicated that Resident #118 had a problem with anesthesia indicated by lethargy and "being out of it." The physician orders, signed on 2/8/2016, were provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m., indicated "PBA [personal body alarm] on at all times to alert staff of unassisted transfers. Confirm placement and function q [every] shift. Bed alarm on when in bed to alert staff of unassisted transfer, confirm placement and function q shift. F/U [follow up] [Physician Name] 2/17/2016 at 10:00 a.m." A document titled "FALL FOLLOW UP" was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m., and indicated Resident #118 had a fall on 2/16/2016 at 6:45 p.m. The incident description indicated LPN #11 found Resident #118 next to his bed laying on his back parallel to the bed. Resident #118 was noted to be "unable to move his left lower extremity" and sent to the emergency room as precaution. Predisposing Physiological factors were listed as "confused, gait imbalance, recent change in cognition, recent illness,			

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	weakness/fainted, impaired memory." Predisposing Situational Factors were listed as "improper footwear, recent room change and side rails up." A document titled "FSI- FALL SCENE INVESTIGATION REPORT" provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m., indicated Resident #118 had an unobserved fall on 2/26/2016 at 6:45 p.m. in room 310. The investigation indicated Resident #118 was resting alone in bed just prior to the fall. The investigation then indicated Resident #118 was unable to verbalize actions at this time as to what he was doing just prior to the fall. The investigation indicated the resident was wearing socks, had no assistive devices and there was no alarm being used at the time of the fall. Root causes of the fall was listed as alarm, footwear, medical status/physical condition/diagnosis and mood or mental status. The fall team meeting notes indicated the alarms did not come with Resident #118 when he transferred from Rose Wood Hall and had no order for them in the electronic medical record . The order for the alarm was on the paper physician orders for Resident #118. A copy of the physician progress note for Resident #118, dated 2/17/2016, was provided by Unit Manager #1 2/23/2016			

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	at 11:36 a.m., indicated "Failed ORIF [open reduction internal fixation] left hip from surgery by [Doctor Name] due to fall. A note signed by the ADON, dated 2/17/2016, was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m., indicated the following "Resident returned from [Name of Orthopedic Physician's Office] with surgery schedule to change hardware to Lt [left] hip r/t [related to] failed ORIF. Daughter reported to nurse that resident's hip was 'broken' and this writer called for clarification. Spoke with PA/NP [Physician Assistant/Nurse Practioner] [PA/NP Name] who assessed resident at appointment. [PA/NP Name] stated that resident's hardware to hip was displaced and no longer in alignment and hardware would have to be replaced. When this writer inquired as to XRAY report from hospital stating 'fractures' [PA/NP Name] stated that fractures that were seen on X-rays were the fractures that occurred with fall which required surgery in the first place. Fractures would not be healed as yet" The Morris Fall Risk Assessment document for Resident #118 was dated 2/8/2016 and was provided by Unit Manager #1 on 2/23/2016 at 2:57 p.m.,			

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	indicated he was at high risk for falling and to implement high risk fall prevention interventions. The care plan for Resident #118 was provided by Unit Manager #1 on 2/23/2016 at 11:36 a.m. It indicated the care plan was initiated on 2/11/2016 and that Resident #118 was high risk for falls related to being unaware of safety needs, confusion, deconditioning and gait/ balance problems. The goal was that Resident #118 would be free of falls with injury through the review date. Interventions included but were not limited to "The resident uses: PBA [Personal Body Alarm]/ bed electronic alarm. Ensure the device is in place as needed." No further information was provided at time of exit on 2/24/16. 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	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			

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	consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview, and record review, the facility failed to ensure residents were free from psychotropic medications without indication for 1 of 5 residents reviewed for unnecessary medications. (Resident #112) Findings include: On 2/22/16 at 9:44 a.m., Resident #112 was observed participating in a ball toss activity in the Rosewood lounge. On 2/22/16 at 2:21 p.m., Resident #112 was observed coloring quietly in a book in the activity room. On 2/23/16 at 10:02 a.m., Resident #112 was observed seated at a table during a group meeting in the activity room.	F 0329	WE REQUEST AN IDR FOR THIS TAG DUE TO THE INTERPRETATION OF THE SURVEYORS BEING INCORRECT REGARDING THE DELUSIONS FOR THIS RESIDENT WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident 112 has a diagnosis of delusions as documented in the 2567. She also has a diagnosis of hallucinations, paranoia with poor judgment and insight. The quarterly MDS did not reflect the breadth of resident 112's behaviors, delusions and behavioral disturbances. On 11/18/15, the physician did not agree to a reduction of her medication due to her increase in agitation. He also recommended continuing the	03/09/2016

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	On 2/24/16 at 9:15 a.m., Resident #112 was observed participating in a ball toss activity in the Rosewood lounge. Review of Resident #112's clinical record began on 2/18/16 at 9:05 a.m. Diagnoses included, but were not limited to, depression and senile dementia with delusions and behavioral disturbances. Resident #112's physician's orders indicated, but were not limited to, the following medications: Seroquel (an antipsychotic) 12.5 mg every evening for agitation, citalopram (an antidepressant) 10 mg once daily for depression, and Depakote Sprinkles (mood stabilizer) 125 mg twice daily for senile dementia with delusions and behavioral disturbances. Resident #112 had a current, 12/11/15, quarterly MDS (Minimum Data Set) assessment, which indicated the resident was severely cognitively impaired and did not have behaviors, delusions, or hallucinations. Review of Resident #112's behavior documentation indicated the following as behaviors and outcomes: Attempting to leave the facility on 8/12/15, 8/19/15, and 8/28/15. The resident was redirected without incident		current medications, frequent redirection and re orientation and frequent distractions when she tries to leave the building. Due to her delusions of thinking that her husband is waiting for her and her thoughts of needing to go to the kitchen to cook, etc., the physician is not willing to reduce the Serequel or the Depakote. Resident 112 continues to wander and exhibit signs of delusions. She is comforted by staff reminding her that she is safe. However, there are times that she repeats these behaviors due to her delusions multiple times daily. Social Service has re-educated the nursing staff regarding the difference between delusions and confusion and the need to document clearly. Activities continues to include her in the "sunshine group" and various activities throughout the day to help her remain stable. The MDS and the care plan have been clarified. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: Any resident who exhibits delusions/hallucinations but those delusions/hallucinations are not documented correctly could be affected. Social Service has audited the charts of any resident that could have	

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	following each attempt. A code alert bracelet was ordered for the resident on 8/12/15. Asking if her family or husband (who was deceased) was picking her up on 8/27/15, 9/21/15, 10/30/15, and 12/31/15. The resident was able to be reoriented or distracted on each date. On 8/29/15, Resident #112 woke at 9 p.m. and thought she needed to go to the kitchen because she thought someone had awakened her. On 10/15/15, Resident #112 was "very confused today" and was noted to be "wandering/looking for her room". Resident #112 voiced a concern of not being able to stay at the facility. The resident was able to be reassured. On 11/29/15, Resident #112 indicated she thought her roommate was living in her apartment for free. The resident was able to be reassured. On 12/7/15, Resident #112 attempted to transfer herself to her bed without asking for assistance. On 12/30/15, Resident #112 transferred herself to bed and did not want to go to supper.		been affected to ensure that there is proper documentation for the use of any anti-psychotropic medication. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Educate staff on the necessity to properly document all behaviors and the difference between confusion and delusions/hallucinations We have contracted with a new Psychiatric Services provider and have a new Psychiatrist who will be looking at all residents to assure there are no unnecessary drugs prescribed. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE There is a monthly behavioral meeting held with the Consultant Pharmacist and will now include the psychiatric services consultant to assure that all pyschotropic medications prescribed are necessary This committee will also work diligently to reduce all medications. The social worker will conduct ongoing monitoring of the documentation of behaviors to assure completion. This will be completed 5 days weekly. The results of the monitoring of documentation and the reduction	

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	On 2/7/16, Resident #112 wanted to lay down instead of going to supper. Review of Social Service notes, dated 6/19/15 through 12/11/15, indicated Resident #112 did not exhibit behaviors. The Social Services note for 6/19/15 indicated the resident was "pleasantly confused". Review of a facility "Behavioral Health Evaluation", dated 8/11/15, indicated the resident's targeted behavior was wandering, which had occurred as an isolated event. Review of a facility "Behavioral Health Evaluation", dated 11/13/15, indicated the resident did not exhibit behaviors. Review of psychiatry progress notes indicated Resident #112 was examined on 8/26/15 by the psychiatrist. Seroquel 12.5 mg was started on this date due to the resident exhibiting sundowning. Review of psychiatry progress notes, dated 9/23/15, indicated the resident experienced delusions and auditory hallucinations. Review of a psychiatry progress note, dated 11/18/15, indicated the pharmacist		of psychotropic medications will be discussed during the monthly QA committee meetings After three (3) months of monitoring, the QA committee will evaluate this plan, making any necessary changes.	

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	had recommended decreasing the Depakote. The psychiatrist declined due to sundowning. The note further indicated the resident did not exhibit delusions or hallucinations. Review of psychiatry progress notes, dated 1/13/16 and 2/10/16, indicated Resident #112's confusion may have been, in part, due to renal (kidney) insufficiency. During an interview, on 2/23/16 at 10:03 a.m., the Social Services designee indicated confusion could be defined as a behavior if actions affect a resident's safety or awareness of safety. She further indicated Resident #112's documented behaviors were mostly the resident exhibiting confusion. During an interview, on 2/23/16 at 11:24 a.m., LPN # 14 indicated Resident #112's behaviors were defined as increased confusion in evening, thinking she needed to go home, or not realizing her husband was deceased. She further indicated the resident's symptoms were not harmful. 3.1-48(a)(4)			
F 0371 SS=F	483.35(i) FOOD PROCURE,			

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Bldg. 00	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, record review and interview, the facility failed to ensure food was stored, prepared, distributed, and served under sanitary conditions. Of the facility's 67 residents, this deficient practice had the potential to impact 65 who were served food from the facility's kitchen. Findings include: 1. Kitchen sanitation tour, accompanied by the Dietary Manager on 2/17/16 at 9:25 a.m. indicated the following: a. Two 12-inch and 10-inch Teflon frying pans were located on a shelf in the food prep area and were ready to use. The pans had multiple scratch marks that were down to the metal where the Teflon was removed. The Dietary Manager indicated she was unaware the Teflon pans should not be used when they were scratched up. b. An observation of the walk-in refrigerator indicated the following:	F 0371	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Teflon pans have been disposed of, the meat slicer has been thoroughly cleaned as has the mixer, cart, and the fans and fan folds located in the walk in and over the food line. The staff have been re educated regarding the cleaning schedules and there is now an audit completed daily regarding the cleanliness of all items to assure compliance. It is important to note that no resident showed any negative signs due to this. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: All residents have the potential to be affected. The Teflon pans have been disposed of, the meat slicer has been thoroughly cleaned as has the mixer, cart, and the fans and fan folds located in the walk in and over the food line. The staff have been re educated regarding the cleaning schedules and there is now an audit completed daily	03/09/2016

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	b1. An uncovered, unlabeled, and undated two quart pitcher of water, a pitcher of chocolate milk, and a partially uncovered and unlabeled pitcher of iced tea. All of the pitchers were located on a cart located under the condenser fans in the walk-in refrigerator. The two grey condenser fan covers had an accumulation of a black substance on them. b2. An unsealed, unlabeled, and undated stainless steel container of green beans with three puncture holes in the aluminum foil that covered the container. The container was located on a shelf in the walk-in refrigerator. b3. A one gallon plastic container of "Extra Fancy Salad Dressing", with a cream colored substance located on the label outside of the container. The Dietary Manager indicated she had the substance on her hand after she had picked up the container. The Dietary Manager indicated there was approximately 1/4 of the container of dressing left. The container was located on a shelf in the walk-in refrigerator. c. A ready to use meat slicer had multiple, dried food particles, cream in color, on the slicer, the base and on the stainless steel cart. The Dietary Manager		regarding the cleanliness of all items to assure compliance. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: An audit of the cleanliness of the equipment in the kitchen is being completed daily by the dietary manager or her designee to assure thorough cleaning is being completed Specific cleaning schedules have been implemented for the mixer, slicer and microwave The Microwave was replaced as well. All kitchen employees have been re-educated on covering of food and drinks. Spot checks will be completed daily by the CDM and/or the Administrator to assure all equipment is clean and that all foods are properly covered and labeled. The fan motors and the vents will be cleaned and documented weekly by Maintenance. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The results of the audit will be discussed during the monthly QA meetings. A Performance Improvement Plan has been designed to assure compliance. This will continue to be monitored for at least one year and until 100% compliance has	

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	indicated the meat slicer, base and stainless steel cart needed to be cleaned. d. A ready to use industrial size mixer had an accumulation of a dried substance, orange and cream in color, splattered on the mixer, mixer base, and underneath the neck of the mixer, as well as on the stainless steel cart the mixer was on. The Dietary Manager indicated the whole mixer and stainless steel cart needed to be cleaned. e. The microwave located on a two tier stainless steel shelf in the food prep area had an accumulation of orange, brown, and cream colored, dried food debris and splatters on the inside door, inside top, sides and bottom of the microwave. The inside bottom of the microwave had multiple dried orange, brown and cream colored spills. The white inside top of the microwave had an area with a black hole with melted plastic around it, approximately the size of a quarter. There was an accumulation of dust and debris on top of the microwave. The outside of the microwave had an accumulation of a sticky substance to the touch and food debris on the touch pad and an accumulation of an orange colored food debris and grease on the side of the microwave near the touch pad. The Dietary Cook indicated the microwave		been achieved for 6 months minimum.	

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	had not been used that morning when asked by the Dietary Manager. f. The white exhaust fan folds, located over the food line and drink area, had an accumulation of a dark grey dust and debris. The Dietary Manager indicated maintenance was in the week prior to clean the exhaust fan folds. She further indicated maintenance was to clean the exhaust fan folds in the kitchen and the condenser fan covers located in the walk-in refrigerator. During an interview with the Dietary Manager on 2/17/16 at 10:22 a.m., she indicated drinks and food items should be covered, labeled and dated, and containers of salad dressing should be wiped down before the items were put away. She further indicated the industrial mixer, meat slicer, and microwave should have been wiped down and cleaned after each use. During an interview with the Maintenance Supervisor #1, on 2/17/16 at 10:52 a.m., he indicated the condenser fans in the walk-in refrigerator were not on his cleaning schedule, but were done when the air conditioning units were inspected and cleaned by an outside contractor.			

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	During an interview with the Administrator (ADM) on 2/19/16 at 9:53 a.m., she indicated there were 65 out of 67 residents who ate from the kitchen on 2/17/16. The ADM further indicated there was a burnt hole on the inside top of the microwave and the microwave would be replaced. During an interview with the Maintenance Supervisor #1 on 2/24/16 at 1:49 p.m., he indicated the condenser fan covers, located in the walk-in refrigerator, were not on the maintenance cleaning schedule at that time. He indicated the last time the condenser fan covers were cleaned was over the summer in 2015, when he had the condensers serviced by an outside contractor. The Maintenance Supervisor #1 further indicated the exhaust fan folds were last cleaned on 12/31/15 and again in January 2016, but had no documentation for the January 2016 cleaning of the exhaust fan folds. He indicated when the exhaust fan folds and condenser fan covers were dirty then they were to be cleaned. A review of cleaning schedules for "Task Cooks", provided by the Administrator on 2/17/16 at 1:00 p.m., indicated no cleaning schedule for the industrial mixer, exhaust fans in the kitchen, or			

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	condenser covers in the walk-in refrigerator. A review of the "Task Cooks" cleaning schedule indicated the following: "...*Clean all items listed at list daily, preferably after each use... ...Microwave oven-clean inside and out after each meal...." The cleaning schedule indicated the microwave was last cleaned on 2/16/16 and 2/17/16. "...Slicer-complete disassemble and clean after each use...." The cleaning schedule indicated the meat slicer was last cleaned on 2/6/16. "...Sanitize work carts-shelves, legs, wheels...." The cleaning schedule indicated the work carts were last cleaned on 2/14/16. A review of an undated policy titled "Sanitation", was provided by the Administrator on 2/19/16 at 9:53 a.m., and indicated the following: "Policy Statement...The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation: ...2. All utensils, counters, shelves, and			

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	equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas...." No further information was provided by exit from the faciity on 2/24/16. 3.1-21(i)(3)			
F 0431 SS=F Bldg. 00	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 reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked, permanently affixed compartments for			

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	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. Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were stored in a hygienic and orderly manner for 1 of 2 medication rooms, 3 of 4 treatment carts, and 5 of 5 medication carts. This practice had the potential to affect 67 of 67 residents residing in the facility. (Dogwood medication room, Dogwood North treatment cart, Rosewood North and South treatment carts, Dogwood and Robin Court medication carts and Rosewood medication carts) Findings include: 1. During a medication pass observation, on 2/23/16 at 8:41 a.m., with RN #13, an open bottle containing Super B Complex vitamin tablets was observed in the left third drawer of the medication cart. The bottle was not labeled for a resident. RN #13 indicated she could not identify who the medication belonged to. 2. During an observation of medication storage on the Dogwood and Robin Court	F 0431	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific resident was affected However, all medications not specifically prescribed for a resident have been removed from the medication room and the medication and treatment carts. The medication and treatment carts have been thoroughly cleaned The narcotic cabinet located in Robin Court medication cart has been repaired and is now attached firmly to the cart. The employee who did not sign out the narcotics has been re-educated and counseled regarding the requirements with further disciplinary action if this happens again All nursing staff have been re-educated on keeping the carts clean and neat. All expired items have been removed. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: All residents have	03/09/2016

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	units, beginning on 2/23/16 at 1:55 p.m., and accompanied by the Dogwood Unit Manager, the following was observed: a. Dogwood and Robin Court medication room cabinet (above sink): Two open and unlabeled bottles of acetaminophen, one marked, "FOR STAFF USE". Eight unlabeled bottles of mutivitamins. Three open bottles of antacid tablets, one marked, "STAFF USE" not labeled for any resident . One open bottle of B complex vitamins not labeled for any resident . Two bottles of B-12 tablets not labeled for any resident. One box of bisacodyl (laxative) tablets not labeled for any resident. One open bottle of aspirin 81 mg tablets not labeled for any resident. One open bottle of Iron 28 mg tablets not labeled for any resident. One vial of ceftriaxone 1 gram (injectable antibiotic) not labeled for any resident. One open 30 gram tube of Santyl (wound debriding) ointment not labeled for any resident. Two bottles of fish oil 1000 mg tablets not labeled for any resident. Five open tubes of muscle rub, one marked "STAFF" not labeled for any resident. Eight albuterol and ipratropium mix unit		the potential to be affected However, all medications not specifically prescribed for a resident have been removed from the medication room and the medication and treatment carts. The medication and treatment carts have been thoroughly cleaned The narcotic cabinet located in Robin Court medication cart has been repaired and is now attached firmly to the cart. The employee who did not sign out the narcotics has been re-educated and counseled regarding the requirements with further disciplinary action if this happens again All nursing staff have been re-educated on keeping the carts clean and neat. The staff has also been re-educated regarding medication administration and labeling. Every medication given should be labeled with the resident's name, date of birth, name of medication, date the medication was filled, directions for administration to compare with the MAR/TAR, and an expiration date. All expired items have been removed. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: An audit tool has been developed to assist management in monitoring the cleanliness of the medication/treatment carts, the accuracy of the	

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	dose vials and one albuterol unit dose vial not labeled for any resident. b. Dogwood North medication cart: Four fluticasone (steroid) nasal sprays in the top left drawer were not labeled with an open date. Two artificial tear eye drop bottles in the top left drawer were not labeled with an open date. A bisacodyl (laxative) suppository was in the top left drawer of the cart, in a basket with bandaids and scissors. There was no label for any resident on the suppository. Twenty-four albuterol (breathing treatment) unit dose vials were unwrapped, loose, in the fourth drawer of the cart and not labeled for any resident. A loose Spiriva (an inhaler) capsule package was observed in the third drawer of the cart. A total of seventeen pills and capsules were observed to be loose throughout the left second, third, and fourth drawers and the right third and fourth drawers of the cart. The cart was observed to have piles of a powdery substance, granules, paper, and capsule pieces in the back of each drawer, with the exception of the narcotic drawer. The edges of the drawers were observed to have a dark grime-like		medications located in the carts, comingling of any medications, and storage in the medication room . All nurses were re-educated on 3/8/16 regarding the cleanliness, storage, labeling and comingling of medications. This audit tool will be utilized 3 X's weekly HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The results of the audit tool will be discussed during the monthly QA committee meetings A Performance Improvement Plan has been written to assist in monitoring this situation Once 100% compliance has been achieved for 6 months, the QA committee will decide whether to continue or discontinue the audits	

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	substance when opened. c. Dogwood South medication cart: A Symbicort 160/4.5 inhaler was in the top left drawer with no open date. A bottle of Combigan eye drops with no open date. A total of eleven pills and capsules were observed to be loose throughout the left second, third, and fourth drawers and the right third and fourth drawers of the cart. The cart was observed to have piles of a powdery substance, granules, paper, and capsule pieces in the back of each drawer, with the exception of the narcotic drawer. The edges of the drawers were observed to have a dark grime-like substance when opened. d. Robin Court medication cart: One unit dose vial of albuterol and ipratropium mix (breathing treatment) was observed to be loose in the top left drawer of the cart. One bottle of artificial tears eye drops were observed in the top left drawer without an open date. A total of 13 pills and capsules were observed to be loose throughout the left second, third, and fourth drawers and the right fourth drawer of the cart. The locked narcotic cabinet in the right			

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	third drawer of the cart was able to be removed from the medication cart. The cart was observed to have piles of a powdery substance, granules, paper, and capsule pieces in the back of each drawer, with the exception of the narcotic drawer. The edges of the drawers had a dark grime-like substance when opened. Three areas of sticky bottle outlines were observed in the left third drawer, with one area observed to have a plastic baggie adhered to it. e. Dogwood North treatment cart: An opened 16 ounce bottle of povidone iodine solution was observed in the second drawer of the cart. The bottle was not labeled for any resident, did not have an open date, and had a reddened, sticky substance down the sides of the bottle. During an interview at the time of the medication storage observation, the Dogwood Unit Manager indicated the pills should not be loose and expired medications should be disposed of. 3. During an observation of medication storage on the Rosewood unit on 2/24/16 at 9:28 a.m., and accompanied by the Rosewood Unit Manager, the following was observed:			

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	a. Rosewood North medication cart: Twenty-five glucometer strips were observed in the top right drawer of the cart with the glucometers. The glucometer strips had an expiration date of January 2016. A spray can of odor eliminating spray was observed in the left third drawer. The drawer contained bottles of medications including, but not limited to, milk of magnesia and Miralax (laxative medications). The narcotic cabinet in the right third drawer of the cart was observed to be unlocked. There was a 4 ounce tube of muscle rub and a 4 ounce tube of Hydraguard (skin protectant) wedged between the drawer and the cabinet. The cabinet was loose and able to be removed from the cart. There was no bottom to the cabinet, allowing the cabinet to be accessed from the bottom of the cabinet. A total of eleven pills and capsules were observed to be loose in the left second, third and fourth drawers of the medication cart. The narcotic count for the cart was unsigned for the date of 2/24/16 by LPN #14. The narcotic count sheet for Resident #20 indicated 76 tablets of oxycodone 5 mg were in the cart. There were 75 tablets observed in the			

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	medication card. The narcotic count sheet for Resident #20 indicated 5 tablets of Tramadol 50 mg were in the cart. There were 4 tablets observed in the medication card. The narcotic sheet for Resident #63 indicated 43 tablets of hydrocodone with APAP 5/325 mg were in the cart. There were 42 tablets observed in the medication card. The cart was observed to have piles of a powdery substance, granules, paper, and capsule pieces in the back of each drawer, with the exception of the narcotic drawer. The edges of the drawers were observed to have a dark grime-like substance when opened. b. Rosewood South medication cart: Three packets of graham crackers and one packet of saltines were observed in the top right drawer of the cart, also containing, but not limited to, glucometers, glucose test strips, and scissors. A total of 2 pills and 3 pieces of pills were observed in the left second, third, and fourth drawers and the right fourth drawer of the medication cart. c. Rosewood North treatment cart: Throughout the second and third drawers of the treatment carts, containing topical medications, including but not limited to,			

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	antifungal medications, steroid creams, and antibiotic creams and ointments, the following was observed: Three 2x2 inch calcium alginate pads observed with the packages open. A 4x4 inch hydrolloid gel pad open and laying in the drawer with topical medications. An uncovered/unwrapped bath puff was observed sitting in a compartment with topical medications. A Xeroform 5x9 inch gauze pad was observed with the package open in a compartment with topical medications. An Endoform 2x2 inch gauze was observed with the package open. An open four ounce bottle of povidone iodine (a skin antiseptic) was observed in the second drawer of the treatement cart. The medication was not labeled for any resident nor was there an open date. The bottle had a sticky, reddened substance running down the sides of the bottle and onto the bottom of the drawer. An open PolyMem (wound dressing) was adhered to the bottom of the drawer, next to the povidone iodine bottle, by a piece of white adhesive wound covering dressing. A box with the top cut out was observed in the third drawer of the treatment cart and contained the following items:			

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	A prescription bag labeled as Kerlix dressing containing two 4x4 inch collagen with silver wound dressings, one of which was observed to be open, with the corner of the dressing cut out of it. A four ounce tube of muscle rub not labeled for any resident. A four ounce tube of Dyna Shield (skin protectant) not labeled for any resident. A one ounce tube of bacitracin (antibiotic) ointment not labeled for any resident. A four ounce tube of antifungal cream not labeled for any resident. One fifteen gram tube and two 30 gram tubes of Nystatin ointment not labeled for any resident. A corroded and leaking AA battery. A can of disinfectant spray was observed in the fourth drawer of the cart. The drawer also contained, but was not limited to, wound dressings. A fifteen gram bottle of Nystatin (antifungal) powder was observed in the top drawer of the cart not labeled for any resident. The medication expiration date was January 2016. Two green-capped wound culture tubes were also observed in the top drawer. The expiration date was July 2013.			

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	The following expired items were observed throughout the second, third, and fourth drawers of the treatment cart: Fourteen calcium alginate 2x2 inch pads, with an expiration date of January 2012. Sixteen calcium alginate 2x2 inch pads with an expiration date of November 2012. A 2.1 ounce tube of capsaicin 0.025% cream with an expiration date of December 2015. A Xeroform 5x9 inch pad with an expiration date of August 2014. d. Rosewood South treatment cart: An open package of graham crackers were observed in the top drawer of the treatment cart. The package was adhered to the bottom of the drawer with a small piece of tape stuck to it, and crumbs spilling around the package. Two small packages of Splenda sweetner were observed near the graham crackers. A set of disposable tweezers were observed in the drawer next to the graham crackers. There was a small amount of a dark substance dried to the tips of the tweezers. A 3 milliliter syringe was observed in the top drawer with the package open.			

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	A half-full, 100 milliliter bottle of normal saline was observed in the top drawer and not labeled for any resident. The following items were observed throughout the second, third, and fourth drawers of the cart: A 3 ounce bottle of antifungal powder not labeled for any resident. A 4 ounce tube of Hydraguard ointment not labeled for any resident. An open package of Kerlix wound dressing. A 22 gram tube of mupirocin 2% (antibiotic) ointment not labeled for any resident. An open package containing a 4x4 inch gauze pad. A loose, unpackaged 4x4 inch gauze pad. The following expired items were observed in the treatment cart: A 4.5 ounce enema with an expiration date of 4/28/15. A 4.5 ounce enema with an expiration date of 8/28/14. A package of 3 povidone iodine swabs with an expiration date of June 2013. Two Xeroform 5x9 inch dressings with an expiration date of October 2015. A CMC/alginate with silver 2x2 inch dressing with an expiration date of March 2013.			

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	During an interview at the time of the medication storage observation, the Dogwood Unit Manager indicated the pills should not be loose and expired medications should be disposed of. She further indicated the evening nurses were responsible for cleaning the carts regularly. Review of a policy, titled "MEDICATION STORAGE IN THE FACILITY", dated January 2007 and December 2013, and provided by the Dogwood Unit Manager on 2/23/16 at 3:01 p.m., indicated the following: "...Medications and biologicals are stored safely, securely, and properly... ...C. Orally administered medications are kept separate from externally used medications such as suppositories, liquids, and lotions... ...H. Potentially harmful substances such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants are clearly identified and stored in a locked area separately from medications... ...I. Schedule II medications are then stored in a separate area under double lock...			

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	...K. The consultant pharmacist or designee routinely monitors controlled substance storage, records... and expiration dates during (monthly) medication storage inspection...." 3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(n)			
F 0441 SS=F Bldg. 00	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. (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. (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			

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	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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure linens were handled in a sanitary manner for 3 of 3 nursing units in the facility. These practices had the potential to effect 67 of 67 residents residing in the faciity. Findings include: On 2/22/16 at 9:26 a.m., a large, three-tiered linen cart was observed at the ambulance and employee entrance of the facility. The cart contained linens including, but not limited to, towels, washcloths, sheets, and blankets. The cart was tightly wrapped with a plastic shrink-wrap material. There was a large hole torn in the plastic of the first and second tier of the cart. At 9:34 a.m., two EMTs entered the facility with a stretcher, which they parked next to the linen cart.	F 0441	WE REQUEST AN IDR FOR THIS TAG DUE TO THE FACT THAT WE WERE TOTALLY UNAWARE OF ANY ISSUE WITH OUR LINEN DURING THE ENTIRE SURVEY PROCESS. THE SURVEYORS HAVE A RESPONSIBLITY TO INFORM THE FACILITY DURING EXIT OF ANY CONCERNS AND THIS WAS ABSOLUTELY NOT BROUGHT TO OUR ATTENTION DURING THE EXIT OR AT ANY TIME PRIOR TO EXIT NOTE OF CONCERN - AT NO POINT DURING THE ACTUAL SURVEY WAS THIS ISSUE ADDRESSED IT WAS NOT NOTED AS AN FYI OR AS A CONCERN AND THIS FACILITY WAS TOTALLY SURPRISED BY THIS DEFICIENCY WE RESPECTFULLY REQUEST THIS TAG BE REMOVED DUE TO THE ABOVE FACT WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO	03/09/2016

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	At 9:38 a.m. a person wearing scrubs entered the facility through the doorway, walking next to the linen cart. At 9:38 a.m., Housekeeper #17 approached the linen cart, pushing a small cart. She proceeded to place linens from the larger cart into the smaller cart, reaching through the hole in the plastic wrap. She covered the small cart with a sheet, which she shook into the air to spread over the cart. The sheet was touching two wheels of the cart as she pushed it to the Rosewood unit linen room. At 9:43 a.m., a visitor left the facility through the door, passing the linen cart as they left. At 9:45 a.m., a man entered the facility through the doors, passing the large linen cart with bags of softener salt on a hand dolly. At 9:48 a.m., Housekeeper #17 returned to the large linen cart, pulled the hole in the plastic down further, and placed linens in the smaller cart, shaking the sheet in the air to cover the cart. The sheet touched the floor while she adjusted the sheet to cover the linens. Housekeeper #17 pushed the small cart to		HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: All residents have the potential to be affected The linen company who delivers our linen will provide a cover for the large cart that will be utilized to assure that the linens are not exposed while the laundry aide is moving them. The Laundry Aide has been re-educated regarding the proper procedure for moving the linen from one place to another. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: A re-education for all employee personnel occurred on 3/4/16 to discuss the need to always keep the linen covered while transporting them and while moving them from the large cart to the smaller cart for easier transport The linen company has started providing a cover in addition to the shrink wrap for our use. The staff has also been educated on assuring that the cover for the small carts do not touch the wheels of the cart or the ground. HOW THE CORRECTIVE ACTION WILL BE	

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	the Dogwood/Robin Court linen closet. At 9:53 a.m., the man with the softener salt on a hand dolly entered the facility again, passing by the large linen cart. At 9:56 a.m., Housekeeper #17 returned to the large cart with the small cart and filled it with linen. She removed a sheet from the large cart, shook it in the air, and covered the linen in the smaller cart. She pushed the cart to the Rosewood linen room. At 10:05 a.m., Housekeeper #17 returned to the large cart with the smaller cart, placed linens in the smaller cart, and shook the sheet in the air to cover the cart. The sheet touched the floor while she adjusted the sheet to cover the linens. Housekeeper #17 pushed the small cart to the Dogwood/Robin Court linen closet. During an interview, on 2/22/16 at 10:43 a.m., Housekeeper #17 indicated the linens used to arrive to the facility covered in a plastic sheet that could be draped over the cart to cover it. She indicated the shrink wrapping made it necessary to rip a hole in it to open it and retrieve the linens. She further indicated the linens should be covered.		MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: An audit will be conducted by the Housekeeping Supervisor at least 3 times weekly to assure that the carts are covered and transported correctly The results of the audit will be discussed during the monthly QA meetings The audits will continue until 100% compliance has been achieved for three months At that time the QA committee will decide whether to continue or discontinue the audits	

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	155718		02/24/2016

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	3.1-19(g)(1)(2)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. It was conducted with the annual Recertification and State Licensure Survey. Survey dates: February 17, 18, 19, 22, 23 and 24. Facility number: 000562 Provider number: 155718 AIM number: 100267150 Residential Census: 23 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R 0000	This Plan of Correction constitutes the written allegation of compliance for deficiencies cited However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly The Plan of Correction is submitted to meet requirements established by state and federal law	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and			

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	telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.			
	Based on observation and interview, the facility failed to post information for contacting advocacy agencies in an area common for residents and visitors for 2 of 2 days of observation. This deficiency had the potential to impact 23 of 23 residents residing in the facility. (2/22/16 and 2/23/16) Findings include: During the initial tour on 2/22/16 at 11:00 a.m., the contact information for advocacy agencies was not observed. During the environmental tour on 2/23/16 at 11:23 a.m., with the Maintenance Supervisor #2, he indicated the agency information should be on the bulletin board in the hall or up by the front door. He indicated it was not there and he did not know where else it would be posted.	R 0033	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific residents were affected HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: All residents have the potential to be affected The required information is framed and posed on the wall directly at the nurses station facing the residents dining room for easy access WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Facility Manager will monitor 3 X's weekly to assure that the sign is not removed HOW THE	03/09/2016

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	During an interview with the Director of Nursing #2, on 2/23/16 at 11:52 a.m., she indicated the agency information was removed when the facility was remodeled in April of 2015 and was not put back in place when the remodel was completed in July or August of 2015. During an interview with the Director of Nursing #2, on 2/23/16 at 12:56 p.m., she indicated she had found the agency information posted on the bulletin board in the short hallway that led into her office from the main hallway. She indicated there would be no reason for anyone to be in the area of the bulletin board unless they were going into her office.		CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of the monitoring will be discussed during the monthly QA committee meeting Once the sign has been visible without being moved for 3 months, the committee will determine whether to continue or not	
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to have the survey results accessible for residents and guests to review for 2 of 2 days of observation. This deficiency had the potential to impact 23 of 23 residents residing in the	R 0042	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE	03/09/2016

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	facility. (2/22/16 and 2/23/16) Findings include: During the initial tour on 2/22/16 at 11:00 a.m., the survey results were not observed. During the environmental tour on 2/23/16 at 11:23 a.m., with the Maintenance Supervisor #2, he indicated the survey results were supposed to be on the table by the front entrance. He indicated they were not there and he did not know what had happened to them. During an interview with the Director of Nursing #2 on 2/23/16 at 11:50 a.m., she indicated the survey results had been moved during the remodel of the facility in April, 2015 and were not put back in place when the remodel was completed in July or August of 2015. During an interview with the Director of Nursing #2 and Activity Staff #3 on 2/23/16 at 11:50 a.m., they both indicated they did not know where the survey results were. On 2/23/16 at 11:52 a.m., Activity Staff #3 indicated the survey results were found behind the nurse's station on the bottom shelf of the chart rack.		AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: All residents have the potential to be affected The survey book is now visible, clearly marked and sitting at the nurses station All staff have been educated on the need to keep it there WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The survey book is now visible, clearly marked and sitting at the nurses station All staff have been educated on the need to keep it there The facility manager will monitor 3 X's weekly to assure compliance HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The results of the monitoring will be discussed during the monthly QA committee meeting After 3 months of monitoring, the QA committee will evaluate this plan, making any necessary changes.	

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance			

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	by written signature. Based on record review and interview, the facility failed to ensure staff had three hours of annual dementia training for 3 of 5 employee records reviewed. (CNA #'s 1, 2 and Activity Supervisor #2) Findings include: Employee records were reviewed on 2/23/16 at 1:45 p.m., with Director of Nursing #2 present. The records indicated the following: CNA #1 was hired on 5/9/02. Review of her 2015 in-service training record indicated she had attended one in-service related to dementia in 2015. The length of the in-service was one hour. CNA #2 was hired on 11/15/00. Review of her 2015 in-service training record indicated she had attended four in-services related to dementia and totaled two and one half hours training. Activity Supervisor #2 was hired 1/20/97. Review of her 2015 in-service training record indicated she had attended four in-services related to dementia and totaled two and one half hours training. During an interview with Director of Nursing #2 on 2/23/16 at 2:03 p.m., she	R 0120	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected due to the lack of Dementia training by the employees All employees discuss dementia and it's effects on residents regularly HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE It is believed that there were no residents actually affected in this situation. Employees at this facility discuss dementia and it's effects on residents regularly. Employees were re-educated by March 9, 2016 regarding the policy and procedure to attend required in-services The three (3) hour per year required dementia training will be offered in one segment that will be offered at least 4 times per year Staff attendance will be monitored at these offerings so that the requirement will be met. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: All employees are required to have the three (3) hours of dementia training. The Facility	03/09/2016

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	indicated CNA #1 and #2 and the Activity Supervisor #2 had not completed their required three hours of annual dementia training for 2015. She indicated when staff missed an in-service it was put out at the nurse's station for them to complete on their own and return to her to her for credit.		Manager will track the attendance and follow up with the employees who do not attend and follow up accordingly. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The Facility Manager will track the attendance at the dementia in-services and follow up with appropriate sanctions for those who do not attend A report will be given to the Administrator following every dementia in-service with the names of the employees who did not attend The results will be discussed during the monthly QA meetings	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights.			

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	(9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure staff received job specific orientation upon hire for 2 of 2 new employee records reviewed. (LPN #4, CNA #5) Findings include: Employee records were reviewed on 2/23/16 at 1:45 p.m., with Director of Nursing #2 present. The records indicated the following: LPN #4 was hired on 8/31/15. LPN #4's employee file lacked an indication of the employee having a job specific orientation when hired. CNA #5 was hired on 8/17/15. CNA #5's employee file lacked an indication of the employee having a job specific orientation when hired. During an interview with Director of Nursing #2 on 2/23/16 at 2:03 p.m., she indicated the facility did not do job specific orientation for new employees.	R 0123	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: It is believed that no residents were affected due to employees not having their orientation checklists completed HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKE PLACE: All residents have the potential to be affected New job specific employee orientation checklists have been started and all employees have had their orientation checklists reviewed and any updated item has been reviewed with the employees. All new employees will receive a job specific checklist. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Facility Manager will monitor and follow up with all new employees within their first 30 days to assure that they have completed the job specific checklists and answer any questions or concerns they might have prior to completing these checklists The files of new	03/09/2016

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			employees will be audited by the Facility Manager or her designee one time monthly to assure completion HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The results of the audit will be discussed during the monthly QA committee meeting to assure compliance Once the audit is at 100% for 3 months, the QA committee will decide on whether to continue or discontinue the audits	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure sliding scale insulin was administered in accordance with physician's orders for 1 of 1 resident reviewed with sliding scale insulin coverage. (Resident #R20) Findings include: Resident R #20's clinical record was reviewed on 2/22/16 at 2:19 p.m. The	R 0241	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #20 has had no insulin/blood sugar regulation issues related to this error. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT	03/09/2016

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	resident's diagnoses included, but were not limited to, diabetes mellitus type II and dementia. The resident had current physician's orders to give Humalog Kwickpen insulin 100u/ml sliding scale coverage before meals as follows: blood sugar of 150 - 200 = 2 units blood sugar of 201 - 250 = 4 units blood sugar of 251 - 300 = 6 units blood sugar of 301 - 350 = 8 units blood sugar of 351 - 400 = 10 units greater than 400 notify the physician. Review of the January, 2016, "Medication Administration Record" indicated the resident had a blood sugar of 241 at 11:00 a.m. on the 6th and received 5 units of Humalog insulin coverage. The resident should have received 4 units of Humalog insulin coverage. The resident had a blood sugar of 321 at 11:00 a.m. on the 13th and received 10 units of Humalog insulin coverage. The resident should have received 8 units of coverage. During a 2/22/16, 3:50 p.m., interview with Director of Nursing #2, she indicated the wrong doses of insulin were given on 1/6/16 at 11:00 a.m. and on 1/13/16 at 11:00 a.m.		CORRECTIVE ACTION WILL TAKE PLACE: Any resident who receives insulin has the potential to be affected Re-education of all nurses was completed on 3/9/16 regarding the need for accurate documentation regarding insulin given as well as the process of transcribing and ensuring the physician's order is taken through the entire and accurate process of implementation. Nursing staff was also re-educated on the five (5) Rights of medication pass. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Facility Manager will observe the administration of insulin at least 3 X's weekly and audit the charts of all residents who receive insulin at least 3 X's weekly to assure that we are following physician's orders as well as accurately documenting HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The results of the audit will be discussed during the monthly QA committee meeting to assure compliance This audit will continue until 100% compliance is achieved for at least three (3)	

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	The 7/12, "Specific Medication Administration Procedures" policy was provided by the Director of Nursing #2 on 2/23/16 at 12:56 p.m. The policy indicated "...C. Checks to Perform Prior to Administration of Medication 1) Check MAR [Medication Administration Record]/TAR [Treatment Administration Record] for order...5) Check the 5 Rights on the Label against the order on the MAR/TAR three (3) times...."		months At that time the QA committee will decide whether to continue or discontinue the audit	