

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155430	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2015
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 20, 21, 22, 23, and 24, 2015</p> <p>Facility number: 000326 Provider number: 155430 AIM number: 100290770</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census Payor type: Medicare; 2 Medicaid: 21 Other: 11 Total: 34</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Rochester respectively requests that this Plan of Correction be accepted and considered for paper compliance.</p>	
F 156 SS=A Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident</p>			

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

TITLE

(X6) DATE

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

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	<p>conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;  A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an</p>			

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	<p>assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interviews, the facility failed to ensure 1 of 3 residents reviewed for discharge from Medicare services received notification in</p>	F 156		05/24/2015

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	<p>a timely manner. (Resident # 40)</p> <p>Finding includes:</p> <p>The clinical record for Resident #40 was reviewed on 04/22/15 at 10:30 A.M. Resident #40 was admitted from an acute care facility following knee surgery on 12/19/14. The resident received therapy and had plans to discharge back to his own home after his therapy was concluded.</p> <p>The OMB (Office of Management and Budget) Approval No. (Number) 0938-0953 form entitled Notice of Medicare Non-coverage, for Resident #40, was not issued and/or signed by the resident until 02/03/15. The resident's last day of coverage was 02/04/15. Under the section to document the reason for non-coverage was the following: "[resident's first name] had his home evaluation with therapy on 01/26/15, and the therapist found that he was safe to return to home. He will be discharged on 02/04/15." The discharge was planned and the notice was not given timely as the resident was not notified of the non-coverage change until 02/03/15, just one day prior to the last day of coverage.</p> <p>During an interview, on 04/24/15 at 2:00 P.M., the Business Office Manager</p>		<p>F156.</p> <p><u>1. What corrective action will be done by the facility?</u> All Notices of Medicare Non-coverage currently prepared, and distributed to any resident at least two days prior to the last covered Medicare day. The Business Office Manager was inserviced on May 8, 2015 by the Administrator on Medicare Non-coverage notification Policy.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> No residents were negatively affected. However, in the future, if the Administrator finds that the notice of Medicare non-coverage is not given timely, she will make sure that the resident and/or legal representative is notified as quickly as possible. Once that is done, she will re-train the</p>	

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	<p>indicated both the Social Service department and the Therapy department were aware of Resident #40's discharge plans and she did not know why the notice of Medicare coverage changes was not provided timely to Resident #40.</p> <p>The facility's current policy and procedure, titled "Medicare - Non-coverage Notices Policy," dated 01/08 and revised on 02/12, was received from the Business Office Manager on 4/24/15 at 2:00 P.M. The policy indicated the following: "...A provider may deliver the notice before the required deadline, and should deliver notice as soon as the last day of covered services can be identified. The notice can be given at any time the facility is aware the services will be discontinued, but at least 2 days prior to the last covered day...."</p> <p>3.1-4(f)(3)</p>		<p>Business Office Manager on the facility notification policy. In addition, written counseling will be given for the continued noncompliance.</p> <p><u>3. What measures will be put into place to ensure that this practice does not recur?</u></p> <p>The Administrator/Designee will monitor the Medicare Non-Coverage Notices routinely five days a week, for 30 days, and then once weekly on an ongoing basis. Any identified concerns will be addressed as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>- Results of the Medicare Non-Coverage Notices will be reviewed at the monthly QA&amp;A committee meeting for 60 days and until 100% compliance is attained</p>	

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F 272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record reviews and interviews, the facility failed to ensure a dietary assessment was thoroughly completed for</p>	F 272	<p><u>Date of compliance: 5/24/15</u></p> <p>F272</p> <p>-</p> <p><u>1. What corrective action</u></p>	05/24/2015

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	<p>2 of 3 residents reviewed for nutrition. (Resident #41 and Resident #17)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #41 was reviewed on 04/22/2015 1:49 P.M. Resident #41 was admitted to the facility on 03/02/15 with diagnoses, including but not limited to: urinary tract infection, urine retention, esophageal reflux, spondylolithesis, malaise and fatigue, iron deficiency anemia, osteoporosis, and history of traumatic fracture. The acute care center history and physical, completed on 02/27/15 indicated the resident was "slight under-nourished white female." The resident was also diagnosed with iron deficiency anemia and urosepsis.</p> <p>The Admission Minimal Data Set (MDS) assessment, completed on 03/09/15, indicated the resident was moderately cognitively impaired with a BMI (Body Mass Index) of 17 (low), independent for eating with set up, and weighed 106 pounds with no indication of weight loss or gain.</p> <p>An admission nursing assessment, completed on 03/02/15, indicated the resident weighed 100 pounds.</p>		<p><u>will be done by the facility?</u></p> <p>A registered dietitian has completed a nutrition assessment for residents #41 and #17. Recommendations have been received and nutrition plans updated accordingly.</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>The Registered Dietitian has completed a review of each resident's nutritional needs. Any recommendations made as a result of those reviews has been forwarded to the physicians for consideration.</p> <p>If any resident is ever found to be at risk for nutritional deficit, he/she will be placed on the Nutrition at risk program</p>	

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	<p>An initial nutritional assessment and progress note, initiated on 03/02/15 and completed on 03/09/15, indicated the resident had been admitted on a regular diet, weighed 106 pounds, had a BMI of 17.1, had her own teeth, was alert, fed herself independently, the caloric needs were crossed out and not figured, the protein needs were 48 grams and the fluid needs were 1440 cc (centimeters) of fluid. In addition, the resident's usual body weight, intakes, and recent lab values were also left blank. The summary indicated there were no specific interventions implemented and the resident was eating well.</p> <p>During an interview, on 04/23/2015 at 9:16 A.M., with Employee #8, the corporate Registered Dietitian, indicated she did not initially recommend a supplement, even though the resident had a low BMI, was under nourished, and had been battling urinary tract infections because the resident was eating well and had gained weight within the first week of admission. The dietician did not comment regarding the incomplete data on the initial nutritional assessment for Resident #41.</p> <p>2. On 4/23/15 at 11:52 A.M., a review of the clinical record for Resident #17 was conducted. The record indicated the</p>		<p>and monitored weekly until the weight is determined to be stable by the Nutrition at Risk committee. Monitoring by the Nutrition at Risk committee will not be less than one month for those identified residents.</p> <p><u>3. What measures will be put into place to ensure that this practice does not recur?</u> A list of residents deemed to have issues that put them at nutritional risk will be provided to the Registered Dietitian each time she enters the facility so that she may assess their nutritional needs and make pertinent recommendations based on that assessment.</p> <p>The Registered Dietitian will review findings with the Dietary Manager and the Director of Nursing prior to exiting the facility to ensure all residents have been reviewed as requested and that the dietitian's recommendations are followed through.</p>	

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	<p>resident was admitted on 1/7/15. The resident's diagnoses included, but were not limited to: arthritis of the spine, mild cognitive impairment and anxiety.</p> <p>The Admission Minimal Data Set (MDS) assessment, dated 1/14/15, indicated the resident was 129 pounds and was 66 inches tall.</p> <p>The resident's current weight for April 2015 was 126 pounds, height was 66 inches. The resident's calculated BMI (Body Mass Index) was 20.3.</p> <p>The Medication Administration Record (MAR) indicated there were no standing labs ordered and no lab results were located in the clinical record.</p> <p>A Nursing note, dated 1/16/15, indicated the IDT (Interdisciplinary Team) met with the resident. The resident's diet was changed to a regular diet with small portions per the resident's request.</p> <p>The Nutritional Admission Assessment and Progress Note, dated 1/28/14, indicated the resident was on a regular diet with no supplements or fortified foods. The quarterly assessment, dated 4/6/15, indicated the resident was on a regular diet with small portions (at resident's request). The resident weighed</p>		<p>The Dietary Manager will review five resident nutrition assessments per week for 30 days, three per week for 30 days and then one assessment each week for 30 days. Findings will be reviewed at the weekly nutrition at risk meeting and then forwarded to the QA&amp;A committee.</p> <p>- If the Dietary Manager finds that the dietitian has not reviewed a resident as requested or has further questions about the recommendations received from the dietitian, she will notify the Administrator of her concerns. She will also notify the dietitian so that interventions can be put into place, pending the dietitian's next visit.</p> <p>- <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> <u>Results of the audits will be forwarded to monthly QA&amp;A committee for review by the Dietary Manager. The QA&amp;A will review until 100% compliance is obtained</u></p>	

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	<p>126 pounds which was a 2% decreased weight change. There were multiple areas of uncompleted data.</p> <p>A care plan, dated 1/15/15, indicated the resident was at risk for problems with nutrition related to mild cognitive impairment, hypertension, hyperlipidemia, depression and anxiety. The interventions included but were not limited to: weight to be monitored, food preferences to be honored, lab work to be monitored as needed and resident to be served a regular diet with small portions, per the resident's request.</p> <p>During an interview, on 4/20/15 at 7:45 P.M., the Director of Nursing (DON) indicated the resident was not on any nutritional supplements.</p> <p>During an interview, on 4/23/15 at 11:25 A.M., the Registered Dietician indicated she had not documented the the resident's BMI, the estimated calorie needs, protein needs and fluid needs on the resident's admission assessment completed on 1/28/15 and the quarterly assessment on 4/6/15. She had not suggested any lab work or concerns during her assessments of the resident. She indicated the resident was currently weighed monthly.</p> <p>On 4/24/15 at 11:37 A.M., a current</p>		<p><u>and then at the discretion of the QA&amp;A committee the audits may be stopped. However, the process as written in #2 and #3 related to the identification of residents at nutritional risk, the dietitian's reviews and recommendations, and the oversight by the Nutrition at Risk and QA&amp;A committees will continue on an ongoing basis.</u></p> <p>- <u>Date of compliance: 5/24/15</u></p>	

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F 325 SS=D Bldg. 00	<p>policy was received from the DON titled "Nutrition At Risk Program" revised on 2/2005. The policy indicated "...5. the dietary manager and/or consulting RD [Registered Dietician] will review all residents identified as being at risk for nutrition...and will recommend appropriate interventions... The dietary manager and/or RD will review and assess residents at nutrition/hydration risk, at a minimum, once a month, and will enter an appropriate progress note in the dietary section of the clinical chart...."</p> <p>3.1-31(c)(5)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interviews, the facility failed to ensure a dietary assessment was thoroughly completed and interventions implemented to assist 1 of 3 residents reviewed for nutrition maintain</p>	F 325	<p>F325</p> <p><u>1,What corrective action willbe done by the facility?</u> Resident #41 had a</p>	05/24/2015

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	<p>acceptable body weight and parameters. (Resident #41)</p> <p>Finding includes:</p> <p>The clinical record for Resident #41 was reviewed on 4/22/2015 1:49 P.M. Resident #41 was admitted to the facility on 03/02/15 with diagnoses, including but not limited to: urinary tract infection, urine retention, esophageal reflux, spondylolithesis, malaise and fatigue, iron deficiency anemia, osteoporosis and history of traumatic fracture.</p> <p>The acute care center history and physical, completed on 02/27/15 indicated the resident was "slight under-nourished white female." The resident was diagnosed with iron deficiency anemia and urosepsis.</p> <p>The Admission Minimal Data Set (MDS) assessment, completed on 03/09/15, indicated the resident was moderately cognitively impaired with a BMI (body mass index) of 17 (low), independent for eating with set up, and weighed 106 pounds with no indication of weight loss or gain.</p> <p>An admission nursing assessment, completed on 03/02/15, indicated the resident weighed 100 pounds.</p>		<p>nutritionassessment completed by the Registered Dietitian on May 7, 2015 with recommendations received and nutrition plans updated to reflect currentcondition.</p> <p><u>2.How will the facilityidentify other residents having the potential to be affected by the samepractice and what corrective action will be taken?</u></p> <p>The weight of all residents is routinely monitored monthly and at intervals established by the Nutrition atRisk committee or as ordered by the physician if the resident is outsideacceptable body weights and parameters.</p> <p>The Registered Dietitian hascompleted a review of each resident's nutritional needs. Any recommendationsmade as a result of those reviews has been forwarded to the physicians forconsideration.</p> <p>If any resident is ever foundto be at risk for nutritional deficit, he/she will be placed on the Nutritionat risk program</p>	

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	<p>An initial nutritional assessment and progress note, initiated on 03/02/15 and completed on 03/09/15, indicated the resident had been admitted on a regular diet, weighed 106 pounds, had a BMI of 17.1, had her own teeth, was alert, fed herself independently, the caloric needs were crossed out and not figured, the protein needs were 48 grams and the fluid needs were 1440 cc (cubic centimeter) of fluid. In addition, the resident's usual body weight, intakes, and recent lab values were also left blank. The summary indicated there were no specific interventions implemented and the resident was eating well.</p> <p>The Dietary progress notes, dated 03/09/15, indicated from the resident's admission on 03/02/15 to the assessment completed on 03/09/15, the resident had gained 6 pounds. The 04/06/15 dietary note indicated the resident's weight was up to 117 pounds with a 17 percent weight gain in 30 days. The note indicated the resident consumed 50 - 75 percent of her regular diet. The only recommendation was to continued to monitor her weight.</p> <p>The resident's hemoglobin and red blood cell counts were low and the resident's protein levels were low on labs taken on</p>		<p>and monitored weekly until the weight is determined to be stable by the Nutrition at Risk committee. Monitoring by the Nutrition at Risk committee will not be less than one month for those identified residents</p> <p><u>3. What measures will be put into place to ensure that this practice does not recur?</u> A list of residents deemed to have issues that put them at nutritional risk will be provided to the Registered Dietitian each time she enters the facility so that she may assess their nutritional needs and make pertinent recommendations based on that assessment.</p> <p>The Registered Dietitian will review findings with the Dietary Manager and the Director of Nursing prior to exiting the facility to ensure all residents have been reviewed as requested and that the dietitian's recommendations are followed through.</p>	

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	<p>04/08/15 but the labs were not addressed in the 04/06/15 note.</p> <p>The current health care plans, initiated on 04/02/15, was a plan for weight gain. There was also a plan to address the resident's constipation. There was a plan to address the resident's anemia but there were no dietary or nutrition interventions. There was a plan indicating the resident was on a regular diet. The interventions included providing the prescribed diet, food preferences honored, weigh resident on a regular basis, able to eat meals in her own room, have a doctor and family updated on her condition.</p> <p>The resident's weight on 04/13/15 was documented as 104 pounds, a 13 pounds weight loss. The reweighs, also on 04/13/15 was 105 pounds, a 12 pound or 10 percent weight loss in just one week.</p> <p>Resident #41 was observed on 04/22/2015 at 11:53 A.M., seated in her wheelchair in the independent dining room. She was dozing but awakened easily and indicated she did feel hungry. Resident #41 was served her lunch on 04/22/2015 at 12:19 P.M. She drank her small glass of orange juice and she was just looking at her food and stated, "I can't tell what this is." Her food items were reviewed with her however, after 5</p>		<p>The Dietary Manager will review five resident nutrition assessments per week for 30 days, three per week for 30 days and then one assessment each week for 30 days. Findings will be reviewed at the weekly nutrition at risk meeting and then forwarded to the QA&amp;A committee.</p> <p>- If the Dietary Manager finds that the dietitian has not reviewed a resident as requested or has further questions about the recommendations received from the dietitian, she will notify the Administrator of her concerns. She will also notify the dietitian so that interventions can be put into place, pending the dietitian's next visit.</p> <p>- <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> <u>Results of the audits will be forwarded to monthly QA&amp;A committee for review by the Dietary Manager. The QA&amp;A will review until 100% compliance is obtained</u></p>	

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	<p>minutes she continued to just stare at her food and had not taken a bite of food. Staff did not notice and did not cue or assist the resident to eat.</p> <p>During an interview on, 4/23/2015 at 9:16 A.M., Employee #8, the corporate Registered Dietician, indicated she did not initially recommend a supplement, even though the resident had a low BMI, was under nourished, and had been battling urinary tract infections because the resident was eating well and had gained weight within the first week of admission. The dietician indicated on the follow up the resident had continued to gain weight. She was unaware of the current weight or the significant weight loss or of the drop in intakes or the decreased laboratory values.</p> <p>The resident's BMI at her highest documented weight of 117 pounds, obtained on 04/06/15 only raised her BMI to 18.9 which was still below the lowest end of the recommended BMI for females of 22.</p> <p>The resident's meal intakes for April 2014 indicated from approximately 04/16/15 through 04/22/15 the resident's intakes had dropped and she was averaging less than 50 percent intake for all three meals.</p>		<p><u>and then at the discretion of the QA&amp;A committee the audits may be stopped. However, the process as written in #2 and #3 related to the identification of residents at nutritional risk, the dietitian's reviews and recommendations, and the oversight by the Nutrition at Risk and QA&amp;A committees will continue on an ongoing basis.</u></p> <p>- <u>Date of compliance: 5/24/15</u></p>		

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	<p>The facility policy and procedure, titled "Weight Monitoring" dated 03/00 and revised on 06/04, provided by the Administrator as a current policy on 04/23/14 at 2:00 P.M., included the following: "2. Any weight that reflects a 5 % weight change will be re-weighted within 24 hours. Once a weight change is confirmed, the licensed nurse will notify the physician, family and dietary manager...5. Unusual or significant weight variances will be reviewed at the next Nutrition at Risk/Standards of Care committee meeting. Unusual or significant weight variances include the following: ...b. Unintentional gain or loss of 5 % or more in one month...6. The Nutrition at Risk/Standards of Care committee will attempt to identify the cause of the weight loss or gain (such as edema, nausea, vomiting, etc) and will document their findings, including new recommendations and interventions, in the residents' medical record. If a significant weight loss is identified, weekly weights will be initiated and will continue for at least 4 weeks. The Committee will re-evaluate the resident's weight and will determine the need for continued weekly monitoring at that time. 7. The RD will review residents with significant weight variance on a monthly basis and will document findings and/or</p>			

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F 371 SS=F Bldg. 00	<p>recommendations in he residents' medical records...." There was no documentation of any interventions provided prior to 04/23/15 when the concern was brought to the facility's attention regarding the decline in Resident #41's nutritional status and weights.</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was stored and prepared in a sanitary manner. In addition the facility failed to ensure kitchen utensils were clean and sanitary. This had the potential to affect 33 of 33 residents who receive meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>1. On 4/20/15 at 6:10 P.M., during the kitchen tour with Cook #1, the following was observed:</p>	F 371	<p>F371. <u>1. What corrective action will be done by the facility?</u> All food is currently prepared, distributed, served and stored per regulations and facility policy. Dietary staff will be inserviced on May 14, 2015 by the Administrator and Dietary Manager on proper food handling and labeling of food containers, sanitation, handling, and storage of</p>	05/24/2015

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	<p>Two ceramic coffee cups with dried lipstick on the rim was observed on a metal drying rack above the dishwasher, on the same metal drying rack 10 insulated plate covers was observed stacked on top of each other, the covers were wet inside. Two plastic food storage containers located in a cabinet under the food prep area were stacked inside each other, the containers were wet inside. One metal serving scoop and one ice cream scoop located inside the top drawer of a Rubbermaid container were put away as clean but had dried food substances inside of them. A bottle of tomato juice was opened, with a date on the lid of 2/25 in cooler #1. Cooler #2 had a bottle of lime juice that was opened and not dated.</p> <p>2. On 4/21/15 at 8:24 A.M., during the kitchen tour with the Dietary Manager, the following was observed:</p> <p>Cooler #1 a bottle of tomato juice was opened with a date on the lid of 2/25. Cooler #2 a bottle of lime juice was opened and not dated. An ice cream scoop and a metal serving scoop was located in the top drawer of a rubber maid container both items were stored away as clean but had dried food substances inside. Two rubber spatulas</p>		<p>utensils, pans, dishes, and other items, checking anddocumentation of temperatures and sanitation levels as required and sanitationin all areas of the kitchen.</p> <p><u>2.How will the facilityidentify other residents having the potential to be affected by the samepractice and what corrective action will be taken?</u></p> <p>No residents were negativelyaffected by dietary concerns. Rubber storage drawers have been removed from thedietary department and replaced with a drying shelf. Staff have beenre-educated on storage and no stacking of utensils, including plate covers. TheDietary manager and Designee will monitor the kitchen area to ensure properlabeling, dating, storage, and documentation of temperatures as required.</p> <p>If the Dietary Manager or designee identifies any</p>	

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	<p>was observed in the second drawer of the rubber maid container. Both were stored in the drawer wet. Two plastic food storage containers, located in a cabinet under the food prep area, were stacked inside each other and were wet inside.</p> <p>During an interview, on 4/21/15 at 8:33 A.M., the Dietary Manager indicated the date on the lid of the tomato juice was probably the date it was received, she further indicated the tomato and lime juice should have been dated when they were opened. The Dietary Manager indicated all dishware should be dried before it is stacked on top of each other, and that all dishes and utensils should be clean before storage.</p> <p>3. On 4/21/15 at 9:05 A.M., the "Food Temperature Checklist," received from the Dietary Manager, indicated no food temperatures were documented for the breakfast and lunch service on 4/8/15, 4/11/15, 4/14/15, 4/16/15 and 4/19/15. Food temperatures were not documented for the evening meal service on 4/9/15 and 4/16/15.</p> <p>The "Low Temperature Dish Machine Log" received from the Dietary Manager indicated no water temperature or sanitizer level was documented for the dishwasher during the lunch service on</p>		<p>concerns regarding the condition of the dietary department or items within, she will first intercede to correct the situation. Once that has been remedied, the Dietary Manager will re-train the staff involved regarding the correct policy and procedure. Progressive disciplinary action will be given for continued noncompliance.</p> <p><u>3. What measures will be put into place to ensure that this practice does not recur?</u></p> <p>The Dietary Manager/Designee will monitor the temperature logs routinely completed by the dietary staff at least 5 days a week for 60 days and then weekly on an ongoing basis. Proper handling, dating and storage of food items and utensils will also be monitored at least 5 days a week for 60 days and then weekly on an ongoing basis. An employee who fails to follow the established policy will be addressed as indicated in question #2.</p>	

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	<p>4/2/15. On 4/9/15, 4/12/15 and 4/16/15 there was no documentation of water or sanitizer level for the lunch or dinner service.</p> <p>During an interview, on 4/21/15 at 9:10 A.M., the Dietary Manager indicated she was having trouble with some staff completing the temperature logs for the food and the dishwasher, and the temp logs should be filled out every shift every day. She further indicated there was no current policy for the storage of dishes or for documenting the temperatures of the dishwasher.</p> <p>On 4/21/15 at 11:03 A.M., the current policy titled "Policy of Meal Temperatures," received from the Dietary Manager, indicated "...Food temperatures will be taken prior to the start of each meal by the cook on duty and recorded either on the Temperature Checklist. All food items that do not register a minimum of 140 degrees F will be returned to the stove and heated until they exceed 140 degrees F. The recorded temperatures will be kept on file...."</p> <p>On 4/23/15 at 11:00 A.M., the current policy titled "Opened Foods Protocol," received from the Dietary Manager, indicated "...When ANY food item is opened, it must be labeled with the date it</p>		<p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>Results of the dietary audits will be reviewed at the monthly QA&amp;A committee meeting for 60 days and until 100% compliance is attained. As indicated in #3, once the 60 day period is over and compliance achieved, the audits and monitoring will continue on an ongoing basis.</p> <p><u>Date of compliance: 5/24/15</u></p>	

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F 441 SS=D Bldg. 00	<p>was opened...."</p> <p>3.1-21(i)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>			

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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure proper handwashing and glove use was used to provide incontinence care for 1 of 2 residents observed receiving care. (Resident #18)</p> <p>Finding includes:</p> <p>During an observation of incontinence care for Resident #18, conducted on 04/24/2015 at 9:26 A.M., CNA #7 was noted to push the stand up lift into the resident's room. Next, CNA #7 washed her hands and started setting up the room to accommodate the process. CNA #6, knocked on the door, entered, and immediately went to the sink and washed her hands. Meanwhile, CNA #7 was noted to blow her own nose and wipe it with a Kleenex. She threw the Kleenex away and stated, "I'll set her up then I'll wash my hands." CNA #7 then proceeded to move the bedside table, handle the resident's oxygen nasal tubing, and touch the stand up lift, the straps and ties of the lift before she washed her hands.. After CNA #7 washed her hands, she put on gloves. CNA #6 had also put on gloves, after she washed her hands.</p>	F 441	<p><u>F441</u></p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>The facility immediately re-educated the staff member on the facility policies related to hand washing and glove use. Following this re-education, the staff member was able to demonstrate the procedure correctly with no errors.</p> <p>The DON will complete an inservice with all staff; regarding the facility policy on infection control, including the appropriate way to perform peri-care, hand washing, and glove use. Each employee will be required to attend and participate in the re-education. Staff will be expected to demonstrate appropriate hand washing technique.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what</u></p>	05/24/2015

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	<p>Resident #18 was then assisted to stand with the lift so her wet brief could be changed. CNA #6 removed the wet brief and discarded it in the trash can. CNA #7, using disposable wipes, provided perineal care for Resident #18. Then without changing their gloves or washing their hands, both CNAs placed a clean brief on the resident and adjusted her outside clothing before they removed their soiled gloves.</p> <p>The policy and procedure titled, "Perineal Hygiene," dated June 2004 and revised on 01/13, provided by the DON (Director of Nursing) on 04/24/15 at 2:00 P.M., provided instructions to put on gloves, but did not give instructions regarding when to remove gloves, wash hands, or change gloves during the process.</p> <p>The policy and procedure titled "Handwashing/Alcohol-Based Hand Rub" indicated the following: "...personnel should always wash their hands (even when gloves are worn): as promptly and thoroughly as possible after contact with ...body fluids, secretions, excretions and equipment or articles contaminated by them, wether or not gloves are worn...after situations during which microbial contaminations of hands is likely to occur, especially those involving contact with mucous</p>		<p><u>corrective action will be taken?</u></p> <p>- No residents have been identified as being affected by this practice. However, if the DON or designee identifies concerns with hand washing or glove use, she will intercede immediately to make sure that the situation is corrected immediately. Once the resident is cared for, the DON will re-train the staff involved on the facility policy for hand washing, glove use, and peri-care technique. If necessary, return demonstrations will occur until compliance is observed. Progressive disciplinary action will be rendered for continued noncompliance.</p> <p>- - <u>3. What measures will be put into place to ensure that this practice does not recur?</u> Each CNA will be observed performing peri-care at least once following the staff re-education. If errors are noted while performing</p>	

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	membranes...after sneezing, coughing, or blowing your nose...."  3.1-18(l)		<p>peri-care, the CNA will receive further instruction and will provide return demonstrations of this technique until done correctly.</p> <p>The DON or designee will randomly choose 2 staff members each week, (at least 1 of the 2 will be direct care staff) and re-evaluate their knowledge of hand washing and glove use. The DON or designee may complete these evaluations either through interview or visually watching as staff performs assigned tasks. Each evaluation will be documented and any need for correction will be handled as indicated in question #2.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The DON or designee will provide the quality assurance committee, with the results of the evaluations at the monthly QA&amp;A meetings. These will continue to be completed for a period of no</p>	

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			<p>less than 6 months. Following a consecutive 6 month period in which the facility has met 100% compliance, the Quality assurance committee may elect to reduce or discontinue these evaluations. However, the DON or designee will continue to randomly observe staff performance with hand washing, gloves, and peri-care at least monthly on each shift on an ongoing basis.</p> <p><u>Date of compliance: 5/24/15</u></p>	