

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2016
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NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00206694, IN00207094, and IN00204892.</p> <p>Complaint IN00206694- Substantiated. Federal/State deficiencies related to the allegations are cited at F441, and F465.</p> <p>Complaint IN00207094- Substantiated. Federal/State deficiencies related to the allegations are cited at F431 and F514.</p> <p>Complaint IN00204892- Substantiated. Federal/State deficiencies related to the allegations are cited at F203, F309, F312, F353, F371, F441, F465, and F9999.</p> <p>Survey dates: August 16, 17, 18, 22, 23, 24, & 25, 2016</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Census bed type: SNF/NF: 76F312, Total: 76</p> <p>Census bed type:</p>	F 0000	<p>Plan of Correction for Cypress Grove Rehabilitation Center 2016 Annual Survey</p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit on September 24, 2016</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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F 0203 SS=D Bldg. 00	<p>Medicare: 5 Medicaid: 51 Other: 20 Total: 76</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on 9/2/16.</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of</p>			

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	<p>transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p>	F 0203	<u>F203Notice Requirements</u>	09/24/2016

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	<p>Based on record review and interview, the facility failed to ensure 1 of 1 residents reviewed for transfers were transferred to another room without notification of the resident's family. (Resident K)</p> <p>Findings include:</p> <p>The clinical record for Resident K was reviewed on 8/23/16 at 1:03 p.m. Resident K had diagnoses including, but not limited to, dementia without behavioral disturbance, anxiety disorder, psychosis, and major depressive disorder. A quarterly MDS (Minimum Data Set) assessment indicated Resident K had a BIMS (Brief Interview for Mental Status) assessment which indicated severe cognitive impairment. The MDS indicated Resident K had no behaviors exhibited.</p> <p>A progress note, dated 6/7/16 at 6:11 p.m., indicated a message had been left on the telephone for Resident K's family member to notify her of a situation between Resident K and another resident on the memory care unit.</p> <p>A progress note, dated 6/8/16 at 11:59 a.m., indicated Resident K had been moved to another room off of the</p>		<p><u>Before Transfer/Discharge</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Family Member for Resident K was notified of room transfer. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents under the care of the facility have the potential to be affected by the alleged deficient practice. ·An audit was completed by Social Services Director (SSD)/designee to identify any resident with room change in last 6 months, and to ensure responsible party was notified of the room change. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ·The Interdisciplinary Team (IDT) and all licensed staff will be re-educated regarding the facility's intra-facility transfer policy and procedure. Education will be provided by the ED/designee and will be completed by 9/24/2016. ·Any resident that has been identified for possible room change will be reviewed by IDT. to ensure proper notification 	

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	<p>memory care unit due to an incident in which a resident had shown a public sign of affection to Resident K.</p> <p>A progress note, dated 6/8/16 at 12:19 p.m., indicated the Social Worker (SW) had spoke with Resident K's family member and informed them that the resident had been moved off of the memory care unit on 6/7/16. The progress note indicated Resident K's family member was unhappy that Resident K had been moved.</p> <p>During an interview on 8/23/16 at 9:35 a.m., the SW indicated Resident K had been moved off of the memory care unit as the facility did not have a bed available for the other resident. The SW indicated she did not realize until the next day that Resident K's family member had not been notified of the move.</p> <p>A policy titled, "Intra facility Transfers", revised 2/2015, and obtained from the DNS (Director of Nursing Service) Consultant on 8/25/16 at 10:15 a.m., indicated notification of the transfer would be made to the resident (if they are their own legal representative) and/or legal representative and recorded on the intra facility form.</p> <p>This Federal tag relates to Complaint</p>		<p>of responsible party is completed prior to room move. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The SSD/designee will be responsible for the completion of the Social Services Documentation Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 09/24/2016</p>	

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F 0241 SS=E Bldg. 00	<p>IN00204892.</p> <p>3.1-12(a)(6)(A)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity was provided to 1 of 3 residents observed eating in the main dining room and 3 of 6 residents reviewed for care. A resident was not served their food at the time of their tablemates, and a resident received care with the curtain opened to the outside. (Resident K, Resident B, Resident N, Resident O)</p> <p>Findings include:</p> <p>1. During an observation on 8/16/16 at 12:36 p.m., Resident K was observed to</p>	F 0241	<p><u>F241 Dignity and Respect of Individual</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident Kis served meals at same time as table mates. ·Privacy is ensured by closing drapes during care for Resident B ·Privacy is ensured by closing door and utilizing privacy curtain during care for Resident O. ·Privacy is ensured by closing blinds during care for Resident N. <p>How will you identify other residents having the potential to be affected by the same deficient practice and</p>	09/24/2016			

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	<p>be sitting in a chair in the main dining room with 2 (two) tablemates. CNA #5 was observed to deliver a deli sandwich, a small bowl of beets, a small bowl of pudding, and a small bowl of fruit to Resident K. After sitting the deli sandwich in front of the resident, CNA #5 removed the sandwich and walked off. Nothing was said to the resident. Resident K's tablemates were observed to eat their meals. At 12:51 p.m., CNA #5 was observed to deliver a cheese spread sandwich, another small bowl of pudding, another small bowl of fruit, and a small bowl of cottage cheese to Resident K. Trays were delivered to residents sitting at 2 (two) other tables and Resident K's tablemates had finished eating before Resident K received her complete meal.</p> <p>2. During an observation on 8/18/16 at 10:00 a.m., CNA #1 and CNA #2 were observed to be providing a bed bath to Resident B. The window drape was observed to be opened to the outside during the bath.</p> <p>During an interview on 8/24/16 at 8:46 a.m., CNA #2 indicated the window drape should have been closed during a bath.</p> <p>During an interview on 8/25/16 at 1:10</p>		<p>what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents under the care of the facility have the potential to be affected by the alleged deficient practice. · Observations were completed on all shifts by DNS/designee to ensure dignity and privacy provided during delivery of care. · Observations were completed by ED/designee during all meals to ensure tablemates served at same time. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All licensed staff will be re-educated regarding the facility's Resident Rights policy and procedure. Education will be provided by the DNS/designee and will be completed by 9/24/2016. · Observational rounds will be completed by DNS/designee daily on all shifts to ensure dignity and privacy are provided during delivery of care. · Observational rounds will be completed by ED/designee daily for all meals to ensure that tablemates are served at the same time. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>		

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	<p>p.m., CNA #6 indicated every resident that was seated at the dining room table should be served before serving another table. CNA #6 further indicated prior to beginning a resident's bath all curtains should be pulled and the door should be closed.</p> <p>3. On 8/23/16 at 9:41 a.m., LPN # 1 was observed to provide wound care to Resident #O's legs. LPN #1, failed to close the door or pull the privacy curtain during Resident #O's wound care.</p> <p>4. On 8/23/16 at 10:11 a.m., ADON (Assistant Director of Nursing) and CEC (Clinical Education Coordinator) were observed to provide wound care for Resident N. Resident N's bed was nearest to the window, facing the courtyard. The ADON and CEC failed to close the blinds during the wound care. During the wound care, Resident N's buttocks was exposed to the window. Residents were observed to be utilizing the courtyard space during the wound care.</p> <p>5. On 8/23/16 at 12:50 p.m., LPN #1 and the ADON were observed to provide wound care for Resident N. Resident N's bed was nearest to the window, facing the courtyard. LPN #1 and the ADON failed to close the blinds to provide privacy for Resident N.</p>		<p>The DNS/designee will be responsible for the completion of the Dignity and Privacy Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 09/24/2016</p>	

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F 0248 SS=E Bldg. 00	<p>On 8/23/16 at 3:15 p.m., LPN #1 indicated doors should be closed and blinds should be drawn during resident care.</p> <p>On 8/25/16 at 10:15 a.m., the Nurse Consultant provided the "Resident Rights" policy, revised 01/2006. The policy included, but was not limited, all staff members recognize the rights of residents at all times and residents assume their responsibility to enable personal dignity, well being, and proper delivery of care.</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing</p>			

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	<p>program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide an on going program of activities to meet the interest and physical, mental and psychosocial well-being of 1 of 3 units reviewed and 1 of 3 residents reviewed in a total sample of 16 residents who met the criteria for activities. Activities were not provided to 8 (eight) residents on the Living Moments (a locked dementia care) unit and 1 resident on the Gardens unit. (Living Moments unit, Resident W)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 8/16/16 at 10:15 a.m., the Living Moments (a locked memory care) unit was observed to have 2 (two) residents sleeping in chairs in the lounge. No activities were observed being offered by Activity Assistant #1 (AA). AA #1 indicated she had just began working yesterday (8/15/16). The activity calendar indicated a "Move and Groove" activity should have been occurring. 2. During an observation on 8/17/16 at 	F 0248	<p><u>F248Activities Meet Interests/Needs of Each Resident</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident Wis being provided with activities that meet his physical, mental, and psychosocial needs. ·Residentson memory care unit are being offered activities according to the activitiescalendar. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Allresidents under the care of the facility have the potential to be affected bythe alleged deficient practice. ·Anaudit of all resident's activity care plans will be completed by ActivitiesDirector(AD)/designee by 09/24/2016 to ensure that activities are identifiedthat meet each resident's physical, mental, and psychosocial needs. ·Observationswere completed by MCF/designee on all shifts to ensure appropriate activitieswere provided per the activities 	09/24/2016

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	<p>11:30 a.m., the Living Moments unit was observed to have 4 (four) residents sitting in chairs in the lounge area, sleeping. A television was on. An activity titled, "Book Club" should have started</p> <p>3. During an observation on 8/23/16 at 10:00 a.m., the Living Moments unit was observed to have 3 residents sitting in the lounge. AA #1 asked Resident A to participate in an exercise activity. Resident A was observed to continue to sit in the chair.</p> <p>4. During an observation on 8/23/16 at 1:20 p.m., the Living Moments unit was observed to have a television playing and 3 residents were observed to be sitting in chairs. No activity was observed being provided by AA #1.</p> <p>An activity calendar for August, 2016, obtained from the AD (Activity Director) on 8/23/16 at 10:10 a.m., indicated the following activities were provided on the Living Moments daily as followed:</p> <p>9:30 a.m.: Morning Report daily Sunday through Saturday each week 10:00 a.m.: Move & Groove daily Sunday through Saturday each week 11:30 a.m.: Cooking Club on Mondays, Book Club on Tuesdays, Wednesdays, and Thursdays</p>		<p>calendar to residents on the memory care unit.</p> <ul style="list-style-type: none"> Observations were completed by AD/designee on all shifts to ensure appropriate activities were provided per each resident's plan of care. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> All activities staff will be re-educated regarding the facility's Activities policy and procedure. Education will be provided by the SSD consultant/designee and will be completed by 9/24/2016. All memory care unit staff will be re-educated regarding the facility's Cottage Activities calendar. Education will be provided by the MCF/designee and will be completed by 09/24/2016. Observations will be completed daily by AD/designee to ensure activities are provided to all residents per each resident's care plan. Observations will be completed daily by Memory Care Facilitator/designee to ensure activities are provided to all residents residing on the memory care unit per the activities calendar. Participations logs for activities will be audited daily to ensure that documentation is present for each resident's participation in activities. 		

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	<p>1:30 p.m.: Quiet Time, TV, or Music Time</p> <p>2:00 p.m., Devotions on Sundays, Mondays, Wednesdays, Thursdays, and Saturdays; Sunshine Sitting on Tuesdays; Table Ball on Fridays</p> <p>2:30 p.m.: Can You Sense It on Thursdays each week</p> <p>3:00 p.m.: Add It Up on Sundays, Bingo on Wednesdays and Fridays, and Sidewalk Artists on Saturdays</p> <p>4:00 p.m.: Sensory Balloons on Monday, Time in the Kitchen on Tuesdays, Sort It Out on Wednesdays, and Book Club on Fridays.</p> <p>6:30 p.m.: Wheel of Fortune on television everyday.</p> <p>Individual activity attendance calendars for the residents on the Living Moments unit indicated the residents did not participate in the activities which were being offered.</p> <p>During an interview on 8/23/16 at 9:35 a.m., CNA #5 indicated the residents on the Living Moments unit needed more stimulation that what was being offered. CNA #5 indicated the residents were not taken outside as it was very difficult for 1 (one) CNA to take them out and get them back in. CNA #5 indicated most of the residents stayed in their rooms and sleep throughout the day or would sit in the</p>		<p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·TheMCF/designee will be responsible for the completion of the Cottage Activity andDining Observation Quality Assurance Tool weekly times 4 weeks, bi-monthlytimes 2 months, monthly times 4 and then quarterly until continued complianceis maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committeeoverseen by the ED. If threshold of 100% is not achieved, an action plan willbe developed. Deficiency in this practice will result in disciplinary action upto and including termination of responsible employee.</p> <p>·TheAD/designee will be responsible for the completion of the Activities QualityAssurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the QAPI committee overseen by the ED. If threshold of 100%is not achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible</p>		

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	<p>chairs in the lounge and sleep. CNA #5 also indicated a small group of residents would go to the main dining room for musical programs occasionally.</p> <p>During an interview on 8/23/16 at 9:45 a.m., the SSD (Social Service Director) indicated the unit had been without an activity person and a memory care facilitator for quite some time. The SSD indicated the facility had hired a new memory care facilitator who was scheduled to start working at the facility next week.</p> <p>5. On 8/17/16 at 2:25 p.m., Resident W was observed to be sitting in the lounge area crying and indicating that he was scared. Resident W resided on the Garden Unit. CNA #5 indicated Resident W was restless and cries at times.</p> <p>On 08/18/2016 at 9:13 a.m., Resident W was sleeping in his wheelchair in the lounge.</p> <p>On 8/18/16 at 9:58 a.m., Resident W was sleeping in his wheelchair in the lounge.</p> <p>On 8/22/16 at 10:41 a.m., Resident W was sitting in his wheelchair in front of the nurses station sleeping.</p> <p>On 8/18/16 at 2:00 p.m., Resident W's</p>		<p>employee.</p> <p>Date of Compliance 09/24/2016</p>	

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	<p>clinical record was reviewed. He had a diagnosis which included, but was not limited to, Alzheimer's.</p> <p>On 8/24/16 at 10:40 a.m., CNA # 7 indicated when she would take Resident W to activities, staff usually would bring him back.</p> <p>On 8/25/16 at 11:00 a.m., the Social Service Director indicated that the activities provided to Resident W were, 1 on 1, giving him a stuffed dog to hold, and providing music for him.</p> <p>A policy, dated 1/2006 and obtained from the DNS (Director of Nursing Services) Consultant on 8/25/16 at 10:15 a.m., indicated the facility would provide an ongoing program of activities...</p> <p>3.1-33(a)</p>			

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F 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a comprehensive assessment was accurate for 3 of 38 residents reviewed. The MDS (Minimum Data Set)</p>	F 0278	<p><u>F278Assessment Accuracy/Coordination/Certified</u> <u>d</u> What corrective action(s) will be accomplished for those residents found to have been affected by the</p>	09/24/2016

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	<p>assessment was incorrectly assessed for an indwelling catheter and a resident with behaviors. (Resident A, Resident B, Resident K)</p> <p>Findings include:</p> <p>1. During an observation on 8/17/16 at 11:00 a.m., Resident A was observed to be in his room. The room had a strong urinary odor.</p> <p>During an interview on 8/17/16 at 11:15 a.m. CNA #7 indicated the resident would urinate in the sink frequently. CNA #7 indicated the staff would clean the sink really well afterwards.</p> <p>The clinical record for Resident A was reviewed on 8/23/16 at 8:00 a.m. Resident A had diagnoses including, but not limited to, Alzheimer's disease, anxiety disorder, and bipolar disorder. A quarterly MDS (Minimum Data Set) assessment indicated Resident A had severe cognitive impairment. The MDS indicated the resident had no behaviors exhibited.</p> <p>2. During an observation on 8/16/16 at 2:52 p.m., Resident B was observed to have an indwelling suprapubic catheter in place.</p>		<p>deficientpractice?</p> <ul style="list-style-type: none"> ·The quarterly MDS assessment forResident A was modified to include behaviors exhibited. ·The significant change MDSassessment for Resident B was modified to include presence of suprapubiccatheter. ·The quarterly MDS assessment forResident K was modified to include behaviors exhibited. <p>How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Allresidents under the care of the facility with catheters or who have exhibitedbehaviors have the potential to be affected by the alleged deficient practice. ·Anaudit was completed by MDSC/designee of residents that have indwellingcatheters or that have exhibited behaviors to ensure proper MDS coding by09/24/2016. <p>What measures will be put into placeor what systemic changes you will make to ensure that the deficient practicedoes not recur?</p> <ul style="list-style-type: none"> ·An in-service will be completed by RAISpecialist with MDSC by 09/24/2016 regarding accuracy of MDS coding. ·The MDS will be reviewed foraccuracy during the weekly IDT care plan review utilizing the 		

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	<p>The clinical record for Resident B was reviewed on 8/18/16 at 9:26 a.m. Resident B had clinical diagnoses including, but not limited to, dementia and urinary retention. A significant change MDS assessment, dated 6/23/16, indicated the resident did not have an indwelling catheter. The MDS further indicated the resident was frequently incontinent of her bladder.</p> <p>During an interview on 8/18/16 at 10:00 a.m., CNA #1 indicated Resident B had a suprapubic catheter which had been in place for a long time. CNA #1 indicated the catheter leaked a lot.</p> <p>3. The clinical record for Resident B was reviewed on 8/23/16 at 1:03 p.m. Resident K had diagnoses including, but not limited to, anxiety disorder, major depressive disorder, dementia without behavior disturbance, and psychosis. A quarterly MDS assessment, dated 5/16/16, indicated Resident B had severe cognitive impairment. The MDS assessment indicated Resident B had no behaviors exhibited. Resident K had a care plan for taking items that do not belong to her and depression.</p> <p>A progress note, dated 6/7/16 at 6:11 p.m., indicated Resident K's family member was called and a message was</p>		<p>care plan reviewtool by the MDSC/designee.</p> <p>How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <p>TheMDSC/designee will be responsible for the completion of the MDS Accuracy QualityAssurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the QAPI committee overseen by the ED. If threshold of 100%is not achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible employee. Dateof Compliance 09/24/2016</p>		

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	<p>left to notify the family member of the incident with Resident A.</p> <p>During an interview on 8/23/16 at 9:45 a.m., the SW (Social Worker) indicated Resident A had been going into the female resident's room prior to the "kissing" incident. The SW indicated the staff had always been able to redirect Resident A in the past but the staff was unable to redirect for this particular incident. The SW further indicated Resident K would often "flirt" with Resident A.</p> <p>Resident K's clinical record lacked documentation of the resident "flirting" with Resident A.</p> <p>During an interview on 8/24/16 at 8:32 a.m., the MDS Coordinator indicated she was new to the position and did not know anything about the residents at this time.</p> <p>A policy, obtained from the DNS (Director of Nursing Service) Consultant on 8/25/16 at 1:44 p.m., indicated the facility would conduct a periodic comprehensive assessment which would be an accurate assessment of each resident's functional capacity.</p> <p>3.1-31(c)(6) 3.1-31(c)(7)</p>			

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents participated in care planning conferences for 1 of 35 residents reviewed during Stage 1 of the survey. (Resident R)</p> <p>Findings include:</p> <p>On 8/17/16 at 10:11 a.m., Resident R indicated she was not included in decisions about her treatments, nor had</p>	F 0280	<p><u>F280Right to Participate Planning Care-Revise CP</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Resident received invitation to, and participated in Care Conference with IDT.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</p>	09/24/2016

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	<p>she been invited to a care planning conference.</p> <p>On 8/18/16 at 2:11 p.m., Resident R's clinical record was reviewed. The Admission MDS (Minimum Data Set) Assessment, dated 7/15/16, indicated Resident R had no cognitive impairment.</p> <p>On 8/22/16 at 3:07 p.m., the SSD (Social Service Director) indicated Resident R should have had a care planning conference upon admission but it had been overlooked.</p> <p>On 8/25/16 at 2:15 p.m., the Administrator provided the "IDT Care Plan Review" policy, revised 4/2014. The policy included, but was not limited to: ...Resident, resident's families or others as designated by resident would be invited to care plan review....</p> <p>3.1-35(d)(2)(B)</p>		<p>taken?</p> <ul style="list-style-type: none"> ·All residents under the care of the facility have the potential to be affected by the alleged deficient practice. ·An audit was completed by SSD/designee to ensure all residents/responsible parties have received invitations to care conference in the last quarter. Care conferences were offered/scheduled/conducted based on the results of this audit. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·An in-service will be completed by ED/designee with IDT by 09/24/2016 regarding IDT care plan review policy. ·The IDT will review care plans schedule daily to ensure that SSD/designee has invited all residents and all responsible parties to Care Plan Conferences quarterly and PRN as the plan of care may change. ·The SSD/designee will send written invitations and will keep a copy of the written invitation as record of the resident being invited <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·The SSD/designee will be responsible for the completion of the Care Plan Review 	

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on, record review, and interview, the facility failed to ensure a medication was administered according to a physicians's order for 1 of 5 resident's reviewed for medications. (Resident D)</p> <p>Findings include:</p> <p>On 8/18/16 at 8:55 a.m., Resident D's clinical record was reviewed. Resident D's diagnosis included but was not limited to, bipolar disorder with psychotic features, dementia, mood disorder, and anxiety. A pharmacy</p>	F 0282	<p>QualityAssurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the QAPI committee overseen by the ED. If threshold of 100%is not achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible employee. Dateof Compliance 09/24/2016</p> <p><u>F282Services by Qualified Persons/Per Care Plan</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficientpractice? ·Resident D is receiving allmedications per physician's orders. How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken? ·Allresidents under the care of</p>	09/24/2016

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	<p>consult report dated 6/3/16 indicated that Resident D's was readmitted to the facility from Transitions (psychiatric unit) on 5/31/16. It further indicated that during the review of the medical record, omissions or errors were found on the medication administration record (MAR), or prescriber order sheets (POS). The following was ordered during the readmission on 5/31/16.</p> <p>1. Lactobacillus (probiotic) two times a day by mouth ordered on 5/31/16 was not on the June MAR or POS. It was not given on 6/1, 6/2, 6/3, 2016.</p> <p>2. Gabapentin (anti-epileptic) on readmission orders read 100 mg (milligrams), give two tablets three times daily for pain/anxiety. The June MAR/POS says 100 mg 1 (one) capsule three times a day. Gabapentin 100 mg by mouth 1 capsule three times a day was given on 6/1, 6/2, 6/3, 2016.</p> <p>3. Vitamin B complex-Vitamin C-Folic Acid capsule is = to Renal Capsule, nursing wrote it on the June MAR twice (once as Renal Capsules and the other as Vitamin B-Vitamin-C-Folic Acid), both documented as given on 6/1/16, 6/2/16, and 6/3/16. This was a double dose.</p> <p>4. Ambien (a sedative) 5 mg every hour</p>		<p>the facility have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> An audit will be completed of all resident by DNS/designee by 9/24/2016 to ensure all residents were receiving medications according to physician's orders. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> An in-service will be completed by DNS/designee with all licensed nursing staff by 09/24/2016 regarding transcription of physicians orders and medication error policy. An audit of all new physician's orders and Medication Administration Records (MARs) will be completed by DNS/designee daily to ensure accurate transcription of orders. An audit of all physician's orders and Medication Administration Records (MARs) will be completed by DNS/designee monthly during re-write process to ensure accurate transcription of orders. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The DNS/designee will be responsible for the completion of the Medication Error Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 	

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	<p>of sleep and 5 mg every hour of sleep as needed, for insomnia was on the readmit orders, but not on the June MAR/POS. Ambien 5 mg by mouth at hour of sleep was not given on 6/1, 6/2, 6/3, 2016.</p> <p>5. Mylanta(antacid), 20 ml (milliliter) by mouth every 4 hours as needed between meals and at bedtime for dyspepsia, was on the readmit orders, but the June orders indicated 30 ml by mouth every 4 hours as needed for indigestion.</p> <p>6. Alprazolam (antianxiety) 1 mg -1/2 tablet (0.5 mg) every 6 hours as needed for anxiety was on the readmit orders, but was not on the June MAR/POS.</p> <p>7. On 5/31/16, the Medication Reconciliation Form indicated to give Risperdal (antipsychotic) 0.5 mg by mouth twice daily. A clarification order dated 6/1/16 indicated to give Risperdal 0.5 mg by mouth three times a day. The July Medication Administration Record indicated that Risperdal 0.5 mg by mouth was given two times a day from July 1, to July 11th, 2016.</p> <p>On 8/23/16 at 11:03 a.m. the Director of Nursing Service Consultant, indicated that Risperdal 0.5 mg by mouth was given two times a day from July 1-11 2016, and should have been given three</p>		<p>months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the QAPI committee overseen by the ED. If threshold of 100%is not achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible employee. Dateof Compliance 09/24/2016</p>	

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F 0309 SS=D Bldg. 00	<p>times a day.</p> <p>On 8/25/16 at 10:15 a.m., the Director of Nursing Services provided a policy indicating the charge nurse would correct findings contributing to the error (i.e. destroy/return discontinued medication, correcting transcription errors to prevent further errors...).</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure care was provided to effectively manage a resident's behaviors for 1 of 4 residents</p>	F 0309	<u>F309 ProvideCare/Services for Highest Well-Being</u> What corrective action(s) will be accomplished for those residents found to have been affected by the	09/24/2016

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	<p>reviewed for behaviors in a total sample of 4 residents who met the criteria for behavioral and emotional status. Resident A would follow a female resident (Resident K) into her room repeatedly. (Resident A, Resident K)</p> <p>Findings include:</p> <p>During an anonymous interview on 8/18/16 at 1:30 p.m., the anonymous person indicated Resident A would follow Resident K into her room frequently. The anonymous person indicated the staff had attempted to redirect Resident A but it did not help and Resident A had continued to do this.</p> <p>1. The clinical record for Resident A was reviewed on 8/23/16 at 8:00 a.m. Resident A had clinical diagnoses including, but not limited to, Alzheimer's disease, anxiety disorder, and bipolar disorder.</p> <p>A care plan, initiated on 2/18/16, indicated Resident A could be very flirtatious and will state ladies were "my girlfriend". The care plan indicated Resident A had a history of kissing peers. Interventions were as followed: Separate from peers with whom Resident A was particularly interested in as a "girlfriend" (6/8/16)</p>		<p>deficientpractice?</p> <ul style="list-style-type: none"> ·Resident A and Resident K reside on different units. ·Resident A is receiving care that effectively tracks and manages his behaviors. ·Resident K is receiving care that effectively tracks and manages her behaviors. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents that receive psychotropic medications and require behavior tracking have the potential to be affected by the alleged deficient practice. ·An audit of nursing documentation and physician orders for all residents will be completed by SSD/designee by 09/24/2016 to identify all residents that are receiving psychotropic medications or require behavior tracking. SSD/designee will ensure any resident identified as requiring behavioral tracking has targeted behavioral symptoms listed on behavior flowsheets, along with nonpharmacological interventions identified that are specific to each resident. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·An audit will be completed daily 				

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	<p>Update the physician as needed and request lab work (added 6/8/16) Encourage visitation only in public areas (initiated 2/18/16) Resident conversation if noted to be flirtatious (initiated 2/18/16) Redirect if noted to seek out female friend in rooms (2/18/16) Walk to room as needed to nap or go to bed (initiated 2/18/16)</p> <p>A progress note, dated 6/7/16 at 3:45 p.m., indicated the following: "Resident had continued to go into another female resident's room. The staff had to ask several times for him to leave resident's room. Every time we (staff) explain to him (Resident A) that he is not allowed in other resident's room, he leaves and comes back in 10 (ten) minutes. Today, pt. (patient) began to stop listening to me (nurse) when I informed him that he had to leave this resident's room, he proceeded to go sit in bed with the resident. I (nurse) politely asked 2 (two) more times for resident to leave the room and he finally did. 10 minutes later resident came back and proceeded to go into pt. room again. Had to ask pt. several times to leave the resident's room. This time female resident was using the bathroom. Resident told me it's okay he is allowed to look and would not leave. Resident finally left female resident's</p>		<p>ofall nursing documentation and behavior tracking flowsheets by SSD/designee toensure documentation of exhibited behaviors or lack of behaviors, as well aseffectiveness of interventions offered to prevent or manage behaviors iscompleted on all shifts.</p> <p>·An in-service will be completed bySSD/designee by 09/24/2016 for all licensed staff regarding completion ofbehavior tracking flow sheets.</p> <p>·Observational rounds will becompleted by SSD/designee on all shifts daily to ensure provision ofinterventions are effective in management of exhibited behaviors.</p> <p>How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <p>·TheSSD/designee will be responsible for the completion of the Behavior ManagementQuality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthlytimes 4 and then quarterly until continued compliance is maintained for 2consecutive quarters. The results ofthese audits will be reviewed by the QAPI committee overseen by the ED. Ifthreshold of 100% is not achieved, an action plan will be developed. Deficiencyin this practice will result in disciplinary action up to and includingtermination of</p>				

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	<p>room. 10 minutes later resident was found back in female resident's room kissing. Called SS (Social Service), DON (Director of Nursing), ED (Executive Director), and both resident's family. To prevent any further issues we put the nursing measure into place to separate them. Female resident was moved to another unit for the night."</p> <p>2. The clinical record for Resident K was reviewed on 8/23/16 at 1:03 p.m. Resident K had diagnoses including, but not limited to, anxiety disorder, major depressive disorder, dementia without behavior disturbance, and psychosis. A quarterly MDS assessment, dated 5/16/16, indicated Resident K had severe cognitive impairment. The MDS assessment indicated Resident B had no behaviors exhibited. Resident K had a care plan for taking items that do not belong to her and depression.</p> <p>A progress note, dated 6/7/16 at 6:11 p.m., indicated Resident K's family member was called and a message was left to notify the family member of the incident with Resident A.</p> <p>During an interview on 8/23/16 at 9:45 a.m., the SW (Social Worker) indicated Resident A had been going into the female resident's room prior to the</p>		<p>responsible employee. Date of Compliance 09/24/2016</p>		

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	<p>"kissing" incident. The SW indicated the staff had always been able to redirect Resident A in the past but the staff was unable to redirect for this particular incident. The SW further indicated Resident K would often "flirt" with Resident A.</p> <p>Resident K's clinical record lacked documentation of the resident "flirting" with Resident A.</p> <p>A policy titled, "Behavior Management Policy", revised "1/2016 and obtained from the DNS (Director of Nursing Service) Consultant on 8/25/16 at 10:10 a.m., indicated interventions would be provided to residents with problematic behaviors which would be individualized</p> <p>...</p> <p>This Federal tag relates to Complaint IN00204892.</p> <p>3.1-37(a)</p>			

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide ADL care to 3 residents reviewed for ADLs (Activities of Daily Living) in a total sample of 23, who met the criteria. Showers were not provided to the residents. (Resident H, K, D)</p> <p>Findings include:</p> <p>1. During an observation on 8/17/16 at 9:11 a.m., Resident H was observed to be propelling himself in a wheelchair in the hall. Resident H was observed to have dirt under his fingernails, stains on his shirt, and his teeth were missing.</p> <p>The clinical record for Resident H was reviewed on 8/23/16 at 1:19 p.m.</p>	F 0312	<p><u>F312ADL Care Provided for Dependent Residents</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident H is being provided showers according to his shower schedule and ADL care per care plan/preferences. ·Resident K is being provided showers according to shower schedule and ADL care per care plan/preferences. ·Resident D is being provided showers according to his shower schedule. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	09/24/2016

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	<p>Resident H had diagnoses including, but not limited to, bipolar disorder, depressive episodes, dementia with behavioral disturbance, and convulsions. A quarterly MDS (Minimum Data Set) assessment, dated 6/21/16, indicated Resident H had a BIMS (Brief Interview for Mental Status) score of 3 (three), which indicated severe cognitive impairment. The MDS indicated Resident H was a extensive assist of 1 person for bathing.</p> <p>A self-care deficit care plan, initiated 12/22/15, indicated Resident H was to receive a shower 2 (two) times per week.</p> <p>The Willows unit shower schedule, obtained from the AD (Activity Director) on 8/18/16 at 8:35 a.m., indicated Resident H was to receive a shower on the day shift every Wednesday and Saturday.</p> <p>The bathing flow record, dated 7/22/16 through 8/21/16, indicated Resident H received a shower on 8/10/16 and 8/17/16. Resident H should have received a total of 6 showers in the time period.</p> <p>2. During an observation on 8/16/16 at</p>		<p>·Allresidents under the care of the facility have the potential to be affected bythe alleged deficient practice.</p> <p>·Anaudit will be completed by ED/designee by 9/17/2016 of all residents todetermine shower preferences, with shower schedule updated accordingly.</p> <p>·Observationscompleted by ED/designee to ensure all residents were provided ADL care percare plan.</p> <p>What measures will be put into placeor what systemic changes you will make to ensure that the deficient practicedoes not recur?</p> <p>·An in-service will be completed by DNS/designee with all staff by 09/24/2016 regarding shower schedule and provisionof ADL care.</p> <p>·Observational rounds will be completed dailyby Customer Care Representatives to ensure appropriate provision of ADL care.</p> <p>·Auditof shower records to be completed by DNS/designee daily to ensure all residentsreceiving showers per preference.</p> <p>How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <p>·TheDNS/designee will be responsible for the completion of the Accommodation ofNeeds Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2</p>	

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	<p>12:30 p.m., Resident K was observed sitting in the dining room for lunch with no teeth in their mouth. Resident K was also observed to have facial hair on her chin.</p> <p>On 8/17/16 at 9:30 a.m., during an interview with Resident K, she indicated she did not get to choose how many times a week she gets a shower, she further indicated she would like more showers. The CNA assignment sheet indicated Resident K was to get showers on Monday and Thursday evenings, with assist of one. Shower sheets for June 2016 indicated that Resident K received 5 of 9 scheduled showers on 6/1, 6/9, 6/13, 6/16, and 6/23. Shower sheets for August, 2016, indicated Resident K received 5 of 9 scheduled showers, 8/2, 8/7, 8/9, 8/11, and 8/22. Showers were not provided two times a week.</p> <p>3. On 8/17/16 at 9:42 a.m., Resident D indicated that he did not choose how many times a week he received a shower. He further indicated that he only received a shower if he arose early, because there were no staff to give it later. The CNA assignment sheet indicated Resident D was to receive a shower on Tuesday and Thursday each week. The annual Minimum Data Set, dated 6/27/16, indicated Resident D was a total assist of</p>		<p>months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 09/24/2016</p>	

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F 0328 SS=D Bldg. 00	<p>one person for showers. Shower sheets, dated April, 2016, indicated Resident D received 2 of 8 scheduled showers, 4/11 and 4/14. The June, 2016, shower sheets indicated Resident D received a shower for 7 of 9 scheduled showers, 6/1, 6/9, 6/13, 6/16, 6/23, 6/27, and 6/30. Showers were not given twice a week .</p> <p>This Federal tag relates to Complaint IN00204892.</p> <p>3.1-38(a)(3)(A) 3.1-38(a)(3)(E)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and</p>			

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	<p>Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper care and treatment was provided for residents with special services for 3 of 6 residents observed . A resident received tracheostomy care incorrectly and a tracheostomy set was not available in the resident's room. A resident was self administering a nebulizer treatment, and another resident's gastric contents were not replaced after feeding tube placement wash checked. (Resident #1, Resident #45, Resident C)</p> <p>Findings include:</p> <p>1. During an observation on 8/16/16 at 10:15 a.m., Resident #1 was observed to be in a chair in the hall. Resident #1 had a tracheostomy.</p> <p>The clinical record for Resident #1 was reviewed on 8/18/16 at 8:44 a.m. Resident #1 had diagnoses including, but not limited to, cerebral vascular accident with right hemiplegia, dementia, and tracheostomy. The MDS (Minimum Data Set) assessment indicated Resident #1 had a BIMS (Brief Interview for Mental Interview) assessment score which indicated severe cognitive impairment,. The MDS indicated</p>	F 0328	<p><u>F328Treatment/Care for Special Needs</u> What corrective action(s) will be accomplished for those residents found to have been affected by thedeficient practice?</p> <ul style="list-style-type: none"> ·Resident #1 is receiving trach careper physicians orders with appropriate technique, and tracheostomy set placedin resident room. ·Resident #45 is self administeringnebulizer treatments per physicians order with facility following care plan andpolicy for self administration of medication. Nursing staff assessing residentbefore, during, and after administration per physician's orders. ·Resident C is receiving enteral tubefeeding and care per physician's orders. <p>How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Allresidents that choose to self-administer medications, who receive enteralfeedings, or who require tracheostomy care have the potential to be affected bythe alleged deficient practice. ·Aaudit of nursing documentation will be completed by DNS/designee by 9/17/2016 toidentify any resident that prefers to self-administer medications. 	09/24/2016			

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	<p>Resident #1 had a tracheostomy.</p> <p>A care plan, initiated 10/27/15 and reviewed on 7/16/16, included, but was not limited to, Resident #1 had a Shiley #4 (a type of tracheostomy tube) reusable inner cannula and was to receive tracheostomy care as needed.</p> <p>Resident #1 had a physician's order, dated 11/24/15, as followed: Trach type: Shiley #4 inner cannula Trach care q (every) shift and as needed with 1/2 strength H2O2 (Hydrogen Peroxide) and sterile H2O (water) and NS (normal saline) Suction as needed Change suction canister 2 (two) times weekly and as needed (Wednesday and Sunday) Change trach ties 2 times weekly (Wednesday and Sunday) and as needed Resident has ambu bag and spare replacement trach at bedside Change trach tube frequency: q 4-6 months per Respiratory Therapy</p> <p>During an observation on 8/18/16 at 1:50 p.m., RN #1 was observed to perform tracheostomy care to Resident #1. RN #1 performed hand hygiene, applied gloves, and removed the clothing protector from around the resident's upper chest area. RN #1 obtained a facial tissue and wiped</p>		<p>·Allstaff were immediately re-educated by respiratory therapist/Clinical EducationCoordinator (CEC) on tracheostomy care with skills validations.</p> <p>·Allstaff were immediately re-educated by Clinical Education Coordinator (CEC) on enteral feeding procedure with skills validations.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·An in-service will be completed by DNS/designee with all licensed nursing staff by 09/24/2016 regarding provision of tracheostomy care and tracheostomy equipment to be kept at bedside.</p> <p>·An in-service will be completed by DNS/designee with all licensed nursing staff by 09/24/2016 regarding enteral feeding procedure.</p> <p>·An in-service will be completed by DNS consultant/designee with IDT members by 09/24/2016 regarding Medication Self-Administration Policy.</p> <p>·An in-service will be completed by DNS/designee with all licensed nursing staff by 09/24/2016 regarding Medication Self-Administration Policy.</p> <p>·DNS/designee will ensure all new staff are observed while</p>				

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	<p>around the upper chest and the tracheostomy sponge. RN #1 indicated she had been employed with the facility as a "prn" (as needed) nurse for 8 months and had just started working full time at the facility. RN #1 indicated she usually worked on the east and locked units. RN #1 indicated she had never removed the inner cannula to clean it and indicated that wiping around the area was what was needed to perform trach care. Upon query, RN #1 indicated she thought Resident #1 was to receive tracheostomy care daily and if the inner cannula needed to be changed, the facility CEC (Clinical Education Coordinator) did it. Upon query, RN #1 indicated she did not know where the spare trach set was in the resident's room and was unable to locate it. RN #1 found a spare trach set in the unit storage area. RN #1 indicated she did not know who was responsible to change the tracheostomy at the facility. Upon further query, RN #1 indicated she did not know what an obturator was and did not know there was an inner and outer cannula to a tracheostomy.</p> <p>During an interview on 8/23/16 at 4:30 p.m., LPN #1 indicated the tracheostomy drainage sponge should be changed when trach care is performed. LPN #1 indicated the inner cannula was to be removed and cleansed with normal saline</p>		<p>completing skills validations for enteral feeding, and tracheostomy care prior to working unsupervised.</p> <ul style="list-style-type: none"> Any resident that self administers medication will be reviewed by the IDT quarterly or with significant change of condition to determine continued ability to self-administer medication. Skills validations for enteral care and feeding procedure, and tracheostomy care will be completed by CEC/designee per the annual calendar. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The DNS/designee will be responsible for the completion of the Inservice-Education Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. <p>Date of Compliance 09/24/2016</p>		

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	<p>and the brush which was in the tracheostomy care kit. LPN #1 indicated she did not know what an obturator was or what is was used for.</p> <p>During an interview on 8/24/16 at 7:50 a.m., LPN #2 indicated what and obturator was and its use, how to perform trach care, and how to clean the inner cannula to the tracheostomy. LPN #2 indicated she had just been inserviced on the tracheostomy and its care.</p> <p>During an interview on 8/24/16 at 1:47 p.m., the facility CEC indicated the facility would place a newly hired nurse with a nurse on the unit to ensure the skills necessary were obtained. The CEC indicated he would be providing the skills necessary and the newly hired nurses would be checked off by him.</p> <p>During a review of RN #1's employee record on 8/24/16 at 2:03 p.m., the skills checklist for RN #1 indicated that RN #1 had a hire date of /13/11. The skills checklist indicated RN #1 had not been checked off on tracheostomy care upon hire.</p> <p>During review of staff's inservices on tracheostomy, obtained from the CEC Consultant on 8/24/16 at 11:05 a.m., the facility was only able to produce 2 (two)</p>			

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	<p>staff members who had received education on tracheostomies.</p> <p>A "Tracheostomy Care Education" form, dated 2013 and obtained from the CEC (Clinical Education Coordinator) on 8/24/16 at 9:00 a.m., indicated tracheostomy care was the process of cleaning the tracheostomy tube and stoma site.</p> <p>2. On 8/23/16 at 12:43 p.m., QMA #1 indicated Resident #45 administered his own nebulizer treatments.</p> <p>On 8/23/16 at 12:47 p.m., Resident #45 indicated he administered his own nebulizer treatments.</p> <p>On 8/24/16 at 9:51 a.m., Resident #45's clinical record was reviewed. The most recent signed physician's recapitulation orders, signed 8/2/16, lacked an order for Resident #45 to self administer his nebulizer treatments. The Quarterly MDS (Mimumum Data Set) assessment, dated 6/23/16, indicated Resident #45 had no cognitive impairment.</p> <p>On 8/24/16 at 9:55 a.m., the Nurse Consultant indicated Resident #45 should have an order to self administer nebulizer treatments.</p> <p>On 8/25/16 at 10:15 a.m., the Nurse</p>			

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	<p>Consultant provided the "Self Administration of Medications" policy, revised 1/2015. The policy included, but was not limited to: A physician order will be obtained specifying the resident's ability to self administer medications and, if necessary, listing which medications will be included in the self administration plan.</p> <p>3. On 8/23/16 at 1:06 p.m., QMA #1 was observed to attempt to administer medications via feeding tube for Resident C. QMA #1 checked the feeding tube for residual. QMA #1 retrieved greater than 120 mL (milliter) gastric contents. QMA #1 retrieved RN #3 for direction. RN #3 instructed QMA #1 to discard the gastric contents. QMA #1 then discarded the gastric contents in the commode.</p> <p>On 8/23/16 at 1:20 p.m., RN #3 indicated she had not instructed QMA #1 to reinsert the gastric contents because it was so much and it had been with stomach acids.</p> <p>On 8/25/16 at 10:15 a.m., the Nurse Consultant provided "Enteral Nutrition-Gastrostomy or Jejunostomy Tube" policy and procedure, revised 9/2012. The policy and procedure included, but was not limited to:Replace gastric content aspirated...</p>			

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F 0329 SS=D Bldg. 00	<p>3.1-47(a)(2) 3.1-47(a)(6) 3.1-47(a)(4)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and</p>			

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	<p>residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 3 of 5 residents reviewed. Behavior monitoring was not in place, and as needed medications were administered without documented prior non pharmacological interventions attempted. (Resident P, Resident #51, Resident R)</p> <p>Findings include:</p> <p>1. On 8/18/16 at 10:42 a.m., Resident P's clinical record was reviewed. Resident P's diagnoses included, but were not limited to: dementia without behaviors, unspecified psychosis, Major Depressive Disorder, anxiety, and insomnia.</p> <p>The most recent signed physicians recapitulation orders, undated, included, but were not limited to: Buspar (an anti-anxiety medication) 5 mg (milligrams), give one tablet, by mouth, every morning for anxiety, ordered on 12/7/15. Zoloft (an anti-depressant medication) 100 mg, give one tablet, orally, at bedtime for depression</p>	F 0329	<p><u>F329Drug Regimen is Free from Unnecessary Drugs</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident P is being monitored for behaviors related to use of psychotropic medication and documentation is present of all offered non pharmacological interventions prior to administration of any prn psychotropic medication. ·Resident R is being monitored for behaviors related to use of psychotropic medication and documentation is present of all offered non pharmacological interventions prior to administration of any prn psychotropic medication. ·Resident #51 is being monitored for behaviors related to use of psychotropic medication with documentation completed daily on each shift of exhibited behaviors or lack of behaviors and effectiveness of interventions. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents that receive 	09/24/2016

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	<p>Zoloft 50 mg, give on tablet, orally at bedtime for a total dose of 150 mg, ordered 5/14/14</p> <p>Trazadone (an anti-depressant medication) 50 mg, give one half tablet, by mouth, at bedtime for insomnia, ordered 6/20/16.</p> <p>Rozerem (a hypnotic medication) 8 mg, give one tablet, by mouth at bedtime, as needed for sleep, ordered 5/27/16.</p> <p>Clonazepam (an anti-anxiety medication) 0.5 mg, one tablet, by mouth, twice a day, order date not listed</p> <p>The August Behavior Flowsheet included: Resident experiences insomnia: Resident exhibits anxiety due to being restless, walking and pacing daily.</p> <p>The clinical record lacked behavior monitoring for April 2016, May 2016, and July 2016.</p> <p>The August MAR (Medication Administration Record) indicated Resident P received Rozerem as needed on: 8/4/16, 8/5/16, 8/7/16, 8/11/16, 8/15/16, 8/16/16, 8/19/16, 8/20/16, 8/21/16, and 8/22/16. The MAR lacked any documented interventions prior to administering the as needed hypnotic medication.</p>		<p>psychotropic medications and require behavior tracking have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> An audit of nursing documentation and physician orders for all residents will be completed by SSD/designee by 09/24/2016 to identify all residents that are receiving psychotropic medications or require behavior tracking. SSD/designee will ensure any resident identified as requiring behavioral tracking has targeted behavioral symptoms listed on behavior flowsheets, along with nonpharmacological interventions identified that are specific to each resident. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> An audit will be completed daily of all nursing documentation and behavior tracking flowsheets by SSD/designee to ensure documentation of exhibited behaviors or lack of behaviors, as well as effectiveness of interventions offered to prevent or manage behaviors is completed on all shifts. Observational rounds will be completed by SSD/designee on all shifts daily to ensure provision of interventions are effective in management of exhibited behaviors. An audit will be completed daily 	

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	<p>The Annual MDS (Minimum Data Set) Assessment, dated 8/1/16, indicated Resident P had active diagnoses including, but not limited to: insomnia, anxiety, and depression. The MDS further indicated Resident P had received an anti-anxiety and anti-depressant 7 (seven) out of 7 days during the assessment period.</p> <p>On 8/22/16 at 2:03 p.m., Resident P was observed walking in the hallway. Resident P indicated he was doing well.</p> <p>2. On 8/18/16 at 10:04 a.m., Resident #51's clinical record was reviewed. Resident #51's diagnoses included, but were not limited to: unspecified psychosis, Major Depressive Disorder, and anxiety.</p> <p>The most recent signed physician's recapitulation orders, undated, included, but was not limited to: Depakote (a mood stabilizer) 125 mg (milligrams) sprinkle, give one capsule, by mouth three times a day for agitation/dementia, ordered on 1/19/12.</p> <p>The Behavior Flowsheet for July 2016, indicated Resident has the potential to be resistive to care, anxious, pinches hit and kicks...</p>		<p>of thenurses notes, behavior events, and MARs for all PRN psychotropic medications bySSD/designee to ensure prior non pharmacological interventions were offeredprior to any PRN medication administration.</p> <ul style="list-style-type: none"> ·An in-service will be completed bySSD/designee by 09/24/2016 for all licensed staff regarding completion ofbehavior tracking flow sheets. ·An in-service will be completed byDNS/designee by 09/24/2016 for all licensed staff regarding provision anddocumentation of non pharmacological interventions prior to administration ofany PRN psychoactive medication. <p>How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·TheSSD/designee will be responsible for the completion of the Behavior Management QualityAssurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the QAPI committee overseen by the ED. If threshold of 100%is not achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including 	

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	<p>The clinical record lacked Behavior Flowsheets for May 2016, and June 2016.</p> <p>On 8/22/16 at 8:38 a.m., Resident #51 was observed in activities. No behaviors were observed.</p> <p>3. On 8/18/16 at 2:11 p.m., Resident R's clinical record was reviewed. Resident R had been admitted on 7/8/16.</p> <p>The most recent signed, physician's recapitulation orders, signed 8/11/16, included, but was not limited to: Ambien (a hypnotic medication) 5 mg (milligrams), give one tablet by mouth, at bedtime, as needed for insomnia, ordered on 7/14/16.</p> <p>A Telephone Order, dated 8/11/16 included, but was not limited to: Hold Ambien, begin Restoril (a hypnotic medication) 15 mg (milligrams) at bedtime. The order further indicated Ativan (an anti-anxiety) medication 0.25 mg, take daily as needed for anxiety.</p> <p>The clinical record lacked behavior monitoring for the use of a hypnotic medication.</p> <p>The August MAR (Medication Administration Record) indicated Ativan</p>		<p>termination of responsible employee.</p> <p>The SSD/designee will be responsible for the completion of the Psychoactive Management Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>Date of Compliance 09/24/2016</p>	

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	<p>had been given on 8/17/16. The clinical record lacked any documented nonpharmacological interventions prior to administering the as needed medication.</p> <p>On 8/22/16 at 12:55 a.m., Resident R was observed sitting on the edge of her bed. Resident R indicated she had been doing well.</p> <p>On 8/23/16 at 10:09 a.m., Resident R was observed sleeping in bed.</p> <p>On 8/23/16 at 3:49 p.m., the Nurse Consultant indicated nonpharmacological interventions should be documented prior to administering an as needed medication.</p> <p>On 8/25/16 at 11:58 a.m., the SSD (Social Service Director) indicated behaviors should be monitored every day, every shift, and documented on the behavior flowsheets.</p> <p>On 8/25/16 at 10:15 a.m., the Nurse Consultant provided the "Psychotropic Management Policy" revised 1/2016, included, but was not limited to:Prior to initiating a psychotropic medication, an assessment will be made of the resident including other potential causes of the behavior which may include</p>			

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F 0353 SS=E Bldg. 00	<p>medical factors, pain, diagnoses....All residents who are taking, antipsychotic, anxiolytic, sedative/hypnotic, or anticonvulsant medication (used for behavioral indication) are require to have a behavior monitoring program in place identifying targeted behavioral symptoms being monitored as well as personalized non pharmacological interventions....</p> <p>3.1-48(a)(3)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other</p>			

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	<p>nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet the needs of the residents for 3 of 3 units, 1 of 3 families interviewed, 6 of 16 residents interviewed, and 3 of 3 staff members interviewed. Residents were unkept, had dirty fingernails and facial hair, and showers were not provided as ordered. (Garden unit, Living Moments unit, Willow unit, Resident G's family member, Resident C, Resident D, Resident E, Resident L, Resident Q).</p> <p>Findings include:</p> <p>1. During an observation on 8/16/16 at 9:00 a.m., the Living Moments (a locked dementia unit) had an activity assistant and a CNA on the unit. The Gardens unit had 1 LPN, 1 QMA, and a CNA on the unit. LPN #3 indicated the CNA from the Gardens unit and the CNA on the Living Moments unit worked together to cover both the units. LPN #3 further indicated she covered both units also. The Gardens unit had 20 (twenty) residents and the Living Moments unit</p>	F 0353	<p>F353Sufficient 24-Hr Nursing Staff Per Care Plans</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> All residents are receiving ADL assistance according to their identified needs per plan of care. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. An in-service will be completed by DNS/designee by 09/24/2016 for all staff regarding appropriate provision of ADL assistance to residents. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Staffing patterns are reviewed daily by ED/designee and adjusted based on identified needs. Weekly review of resident ADLs per unit will be reviewed by DNS/designee and adjustment to 	09/24/2016			

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	<p>had 8 residents on it. The Garden unit had 5 (five) residents who required a mechanical lift for transfers and 4 residents who required 2 persons for transfers.</p> <p>2. During an observation on 8/18/16 at 10:05 a.m., the Willows unit had 1 nurse and 2 CNAs working. The Willow unit had 48 residents on it, of which 7 residents required a mechanical lift for transfers and 6 residents residents required the assistance of 2 persons for transfers.</p> <p>3. During an observation on 8/16/16 at 12:30 p.m., Resident K was observed sitting in the dining room for lunch with no teeth in their mouth. Resident K was also observed to have facial hair on her chin.</p> <p>4. During an observation on 8/17/16 at 9:11 a.m., Resident H was observed to be in the hall in a wheelchair. Resident H had a stain on his shirt, his fingernails were dirty, and his teeth were missing.</p> <p>5. During an interview on 8/16/16 at 12:00 p.m., Resident E indicated the facility was short staffed. Resident G indicated she has had to wait for over 45 (forty-five) minutes for help to arrive at times. Resident G further indicated the</p>		<p>staffing will be made to reflect changes in resident ADL needs</p> <ul style="list-style-type: none"> ·Customer Care Representatives/designees will complete daily observational rounds on all shifts to ensure that residents are receiving ADL assistance according to their identified needs per plan of care. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·The DNS/designee will be responsible for the completion of the Accommodation of Needs Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. <p>Date of Compliance 09/24/2016</p>		

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	<p>facility had only 1 CNA working on the unit during the night.</p> <p>6. During an interview on 8/16/16 at 2:33 p.m., Resident C indicated the facility was short of staff often during the day time and also the night shift did not have enough staff on it.</p> <p>7. During an interview on 8/16/16 at 3:25 p.m., Resident L indicated the facility was short staffed on each shift. Resident L indicated she has had to wait for over 45 minutes in the past to be assisted off of the commode. Resident L indicated she now had a bedside commode so she can transfer herself.</p> <p>8. During an interview on 8/17/15 at 9:00 a.m., Resident Q indicated the facility was "very short handed all the time."</p> <p>9. During an interview on 8/17/16 at 10:33 a.m., Resident R indicated the facility was short staffed on some of the shifts.</p> <p>10. During a family interview on 8/17/16 at 10:31 a.m., the family member of Resident A indicated the weekends are very short on staff.</p> <p>11. During an anonymous interview on</p>			

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	<p>8/18/16 at 1:30 p.m., the anonymous caller indicated the facility worked short especially on the night shift. The anonymous caller indicated the residents were not receiving good care.</p> <p>12. During an interview on 8/23/16 at 7:30 a.m., RN #2 indicated she worked the night shift. RN #2 indicated the facility usually had 1 nurse on the night shift to cover the Garden and Living Moments units with 2 CNAs.</p> <p>13. During an interview on 8/24/16 at 7:59 a.m., LPN #2 indicated the facility was often short of staff on the night shift. LPN #2 indicated the facility seemed to try to staff the facility, but the facility had a lot of staff which would call in and not be replaced.</p> <p>14. During an interview on 8/24/16 at 11:26 a.m., CNA #5 indicated the residents on the Living Moments unit sat in chairs all day or would lie in their beds. CNA #5 indicated it was very difficult to take the residents outside with only 1 CNA on the unit. CNA #5 indicated the unit needed to have a nurse on it at all times due to the resident's behaviors.</p> <p>15. During an interview on 8/24/16 at 11:15 a.m., LPN #3 indicated the facility</p>			

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	<p>was short staffed frequently. LPN #3 indicated the Living Moments/Gardens units were to have 2 nurses and 3 CNAs covering the units, but the facility never had the staff to staff it appropriately.</p> <p>16. During a review of the Alzheimer's "Dementia Special Care Unit Disclosure" (a form used for the Living Moments unit), dated 12/1/15, the form indicated the unit was to have 1 full time LPN on the day and evening shift with a 0.5 hour LPN on the night shift, 2 CNAs on the day and evening shifts and 1 full time CNA on the night shift, 1 activity director/staff on the day and evening shift, and 0.5 hours for the Social Worker on the day and evening shifts.</p> <p>16. The Resident Council Minutes, dated from 9/22/15 through 7/24/16, were reviewed on 8/24/16 at 9:10 a.m. The minutes indicated call lights were not being answered in a timely fashion, beds were not changed completely on shower days, snacks were not being passed in the evenings, and bedside commodes were not being emptied.</p> <p>16. During an interview with the Adm (Administer) on 8/25/16 at 8:15 a.m., the Adm indicated the facility had been searching for staff, but the help was just "not out there." The Adm indicated the</p>			

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F 0371 SS=E Bldg. 00	<p>facility had recently hired several new staff members.</p> <p>The facility lacked documentation of a policy for staffing.</p> <p>This Federal tag relates to Complaint IN00204892.</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F 0371	<p><u>F371Food Procure, Store/Prepare/Serve-Sanitary</u> What corrective action(s) willbe accomplished for those</p>	09/24/2016

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	<p>that food was prepared and served under sanitary conditions. The Dietary Manager was observed to not have his facial hair covered on two observations, food was uncovered in a refrigerator with no date, the refrigerator shelves were dirty, a open container of outdated applesauce was on a medication cart, for 2 of 2 observations of the kitchen, and 2 of 3 of the pantries. (Willow unit pantry, Gardens unit pantry)</p> <p>Findings include:</p> <p>1. During an observation on 8/24/16 at 8:22 a.m., the Willows unit pantry was observed. The resident nourishment refrigerator was observed to have an open container of French onion dip with no date on it, an opened container of ranch dip with no date on it, a bottle of classic whipped dressing with no date on it, an opened container of honey-thickened orange juice with no date on it, a bowl of applesauce with no date or label on it, an open container of cream cheese with no date on it, and a sack in a drawer with lunch meat in it with no date. The freezer had 2 sandwiches in a bag with no label or date on them. The refrigerator shelves were dirty with food particles and spilled liquids, and the ice maker in the Willow pantry room was observed to have rust around the opening where the lid would close onto the opening and the lid was</p>		<p>residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> The refrigerator in the Willows pantry has been cleaned. All food and drinks that were not labeled and dated has been removed and discarded. All food and drinks in the refrigerator in the Willow pantry are labeled and dated. The refrigerator on the Gardens unit has been cleaned and is free of food particles and spills. Only resident food and drinks are stored in the pantry refrigerators. The applesauce on the Gardens medication cart has been removed and discarded. The Dietary Manager utilizes beard covers while in the dietary department. The door to the ice machine was repaired and is free of rust/cracks. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All other residents that reside in the facility have the potential to be affected by the alleged deficient practices. All refrigerators were inspected by the Dietary Manager/designee to ensure they were clean and free of food and drinks that were not labeled and dated. All medication carts were inspected and are free of outdated applesauce. Dietary staff has been 	

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	<p>cracked.</p> <p>During an interview with CNA #2 on 8/24/16 at 8:26 a.m., CNA #2 indicated she did not know who was responsible for cleaning the refrigerator. She indicated the employees foods should probably not be in the nourishment refrigerator.</p> <p>2. During an observation on 8/24/16 at 8:44 a.m., the Gardens unit pantry was observed. The nourishment refrigerator's shelves were dirty with food particles and spilled, dried liquids.</p> <p>During an interview with LPN #3 on 8/24/16 at 8:45 a.m., LPN #3 indicated she did not know who was ultimately responsible for cleaning the refrigerator.</p> <p>3. On 8/22/16 at 11:21 a.m., a container of applesauce was observed sitting on the medication cart on the Garden Suites Unit. The applesauce was dated 8/20/16 and had a use by date of 8/21/16 at 8:00 p.m.</p> <p>On 8/23/16 at 9:38 a.m., the same applesauce was observed on the Garden Suites Unit medication cart.</p> <p>On 8/23/16 at 12:13 p.m., the same applesauce was observed on the Garden</p>		<p>re-educated onthe cleaning schedule of refrigerator, utilizing beard covers, and disposing offood after the discard date.</p> <p>What measures will be put into placeor what systemic changes you will make to ensure that the deficient practicedoes not recur?</p> <p>·Dietary staff have been re-educated onthe cleaning schedule of refrigerators, proper labeling/dating, and utilizingbeard covers. Nursing staff have been re-educated on disposing of food afterthe discard date. The Dietary Manager/designee will complete the "DietaryManager Daily AM Check List" daily and inspect the refrigerator to ensure thecleaning schedule is being followed and food that is being stored is properlylabeled and dated. The DNS/designee will inspect medication carts daily toensure applesauce is not being used past the disregard date.</p> <p>How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <p>·TheED/designee will be responsible for the completion of the Manager AM DailyInspection Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2months, monthly times 4 and then quarterly until continued compliance ismaintained for 2 consecutive quarters. The results of these audits will be reviewed</p>		

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	<p>Suites Unit medication cart. Two days after the use by date of 8/21/16.</p> <p>4. 08/16/16 at 8:50 a.m., the Dietary Manager was observed to not have a beard cover over his facial hair. On 8/18/16 at 10:42 a.m., the same was observed.</p> <p>On 8/24/16 at 8:08 a.m., the Administrator indicated that facial hair should be covered by staff if working in the kitchen.</p> <p>On 8/24/16 at 1:15 p.m., the Director of Nursing Services provided a policy on food safety. The policy indicated that dietary staff must have hair restrained.</p> <p>This Federal tag relates to Complaint IN00204892.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 09/24/2016</p>	

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F 0425 SS=D Bldg. 00	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure residents medications were provided for 1 of 5 residents reviewed for unnecessary medications. A sedative medication was not delivered for 7 (seven) days. (Resident R)</p> <p>Findings include:</p>	F 0425	<p><u>F425Pharmaceutical SVC- Accurate Procedures-RPH</u> What corrective action(s) willbe accomplished for those residents found to have been affected by thedeficient practice? ·Resident R is receiving allmedications per physician orders. How will you identify otherresidents having the</p>	09/24/2016

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	<p>On 8/17/16 at 10:11 a.m., Resident R indicated the nurse practitioner had ordered her a different sleep aid medication. Resident R indicated after two nights of the medication not coming in, the facility contacted the pharmacy. Resident R indicated at that time she was notified she would get the medication on the following Monday (8/15/16). Resident R indicated she did not receive the medication on 8/15/16. Resident R indicated she had been without a sleep aid medication for six nights.</p> <p>On 8/18/16 at 2:11 p.m., Resident R's clinical record was reviewed. Resident R had been admitted on 7/8/16. A Telephone Order, dated 8/11/16 included, but was not limited to: Hold Ambien (a hypnotic medication), begin Restoril (a hypnotic medication) 15 mg (milligrams) at bedtime.</p> <p>The August MAR (Medication Administration Record) indicated Restoril had not been given 8/11/16 through 8/17/16. The MAR further indicated on 8/16/16, the medication was not given because it was not available.</p> <p>A Progress Note, dated 8/17/16, indicated the resident had trouble sleeping and was awake in the lounge area. The note further indicated triage had been called</p>		<p>potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. All nursing staff will be re-educated by DNS by 09/17/2016 on procedure for obtaining new medications from pharmacy. An audit of all MARS and nursing documentation was completed by DNS/designee daily to ensure timely provision of all medications per physicians orders. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> All new physician orders will be reviewed daily by DNS/designee to ensure timely provision of medications. An in-service will be completed by DNS/designee by 09/24/2016 for all nursing staff regarding procedure for procuring medications from pharmacy at the time the medications are ordered. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The DNS/designee will be responsible for the completion of a modified version of 	

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	<p>about the medication not coming from pharmacy on that night.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 7/15/16, indicated Resident R had no cognitive impairment.</p> <p>On 8/22/16 at 8:45 a.m., Resident R indicated she had received her sleep aid medication the previous night.</p> <p>On 8/22/16 at 10:35 a.m., the CEC (Clinical Education Coordinator) indicated Resident R's Restoril's delivery had been delayed because the pharmacy had not received a hard prescription for the medication. The CEC indicated the medication was not stored in the emergency drug kit.</p> <p>On 8/23/16 at 10:09 a.m., Resident R was observed sleeping in bed.</p> <p>On 8/25/16 at 10:15 a.m., the Nurse Consultant provided the "Medication Pass Procedure" policy, revised 6/2016. The policy included, but was not limited to: medications administered within 60 minutes before and/or after time ordered.</p> <p>3.1-25(a)</p>		<p>thePharmacy Services Quality Assurance Tool weekly times 4 weeks, bi-monthly times2 months, monthly times 4 and then quarterly until continued compliance ismaintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committeeoverseen by the ED. If threshold of 100% is not achieved, an action plan will bedeveloped. Deficiency in this practice will result in disciplinary action up toand including termination of responsible employee.</p> <p>Date of Compliance09/24/2016</p>		

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F 0431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>			

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	<p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure medications were administered to the resident in the presence of the staff for 1 of 35 residents reviewed (Resident #T).</p> <p>Findings include:</p> <p>On 8/16/16 at 12:00 p.m., during an interview with Resident T, a cup of pills were observed to be on the bedside table.</p> <p>On 8/24/16 at 11:45 a.m., the Director of Nursing indicated that the facility policy indicated for nursing to watch the resident's take their medications, not leave them at bedside.</p> <p>On 8/25/16 at 10:15 a.m. a policy was provided by the Director of Nursing Services that indicated medications are to be observed taken, not left on the bedside.</p> <p>This Federal tag relates to Complaint</p>	F 0431	<p><u>F431Drug Records, Label/Store Drugs & Biologicals</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident T is receiving all medications in the presence of staff. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All resident have the potential to be affected by the alleged deficient practice. An in-service will be completed by DNS/designee by 09/24/2016 with all nursing staff regarding medication pass procedure. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Observational rounds will be completed by the DNS/designee 	09/24/2016

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Bldg. 00	<p>SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based observation, interview, and record review, the facility failed to ensure a infection control practices were</p>	F 0441	<u>F441Infection Control, Prevent Spread, Linens</u> What corrective action(s) willbe accomplished for those	09/24/2016

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	<p>implemented for 2 of 6 residents reviewed. Wounds were not cleaned properly and community ice was retrieved by a resident. (Resident P, Resident N)</p> <p>Findings include:</p> <p>1. On 8/18/16 at 1:58 p.m., Resident P was observed to retrieve a key from behind the nursing station. Resident P used the key to enter the pantry. Resident P exited the pantry with a fresh glass of ice and carrot cake.</p> <p>2. On 8/18/16 at 8:27 a.m., Resident N's clinical record was reviewed. A Telephone Order, dated 7/18/16, indicated to culture the left hip area. A Final Wound Culture Report, dated 7/23/16, indicated the wound had multiple drug resistant organisms were present.</p> <p>On 8/18/16 at 3:08 p.m., the Nurse Consultant indicated he would isolate a resident with the Wound Culture Report that indicated multiple drug resistant organisms.</p> <p>On 8/22/16 at 10:21 a.m., the CEC and CEC Consultant were interviewed. The CEC and CEC Consultant indicated they would not isolate a resident unless the</p>		<p>residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident P is no longer able to access key to communal pantry. Staff is following infection control policy while providing wound care to Resident N. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. No other residents have access to the ice machine in the communal pantry. An audit of all lab culture results will be completed by the DNS/designee to identify residents requiring contact isolation precautions. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> An in-service will be completed by the DNS consultant/designee to the IDT members regarding criteria for contact isolation. An in-service will be completed by the DNS/designee by 09/24/2016 for all nursing staff regarding appropriate infection control practices and observation of contact isolation precautions during wound care. 	

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	<p>culture report indicated ESBL (Extended Spectrum Beta Lactamase) or MRSA (Methicillin Resistant Staphylococcus Aureus).</p> <p>On 8/23/16 at 10:11 a.m., the ADON and CEC were observed to provide wound care for Resident N. No contact isolation precautions were observed to be implemented. The ADON and CEC entered Resident N's room, performed hand hygiene and donned gloves. The ADON and CEC uncovered Resident N and began to turn him to the left. Resident N indicated he was in pain from an item stuck to his lower extremities. A rolled up towel was observed under leg wounds on both of Resident N's lower extremities. The rolled up towels were observed to be stuck to Resident N's legs because of dried drainage. The ADON removed the rolled up towels, removed her gloves, performed hand hygiene, and donned a clean pair of gloves. The ADON removed a dressing from Resident N, which extended from the posterior pubic area to the posterior mid thigh. The dressing was observed to be visibly soiled with drainage. Active bleeding was observed on Resident N's buttocks. The ADON spayed Resident N's buttocks with wound cleanser and used a 4 by 4 gauze to dry the wound. The ADON was observed to wipe the</p>		<p>·An in-service will be completed by the DNS/designee by 09/24/2016 for all nursing staff regarding appropriate infection control practices in communal pantry areas.</p> <p>·Observational rounds will be completed by DNS/designee on all shifts daily to ensure infection control practices are being followed in communal pantry areas.</p> <p>·Observational rounds will be completed by DNS/designee on all shifts daily to ensure infection control practices are being followed during provision of wound care.</p> <p>·ED will attend resident council, with permission, to address with residents not obtaining ice from ice machine without assistance from staff.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·The DNS/designee will be responsible for the completion of the Infection Control Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this</p>	

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	<p>wound cleanser off of Resident N's buttocks. The ADON removed her gloves, performed hand hygiene, and donned clean gloves. The ADON applied the dressing to Resident N's pressure areas. The ADON replaced the draw sheet and Resident N was turned to the right side. The CEC was observed to use the soiled draw sheet to scoop flaked dry skin off of Resident N's mattress into the CEC's gloved hand. The ADON and CEC were not observed to cleanse between Resident N's thighs nor were the observed to cleanse the far left portion of Resident N's buttocks.</p> <p>On 8/23/16 at 12:08 p.m., the DON and Nurse Consultant were queried regarding Resident N's isolation precautions. The Nurse Consultant indicated a modified contact isolation would be appropriate for Resident N.</p> <p>On 8/23/16 at 12:50 p.m., LPN #1 and the ADON were observed to provide wound care for Resident N. Contact isolation precautions were observed to be implemented. The ADON lifted Resident N's right leg up from the bed. Drainage was observed to present on the mattress. LPN #1 was observed to clean the drainage up from the mattress with a peri wipe.</p>		<p>practicewill result in disciplinary action up to and including termination ofresponsible employee.</p> <p>Dateof Compliance 09/24/2016</p>	

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	<p>On 8/22/16 at 10:49 a.m., the CEC Consultant provided the "Multiple Drug Resistant Organisms" policy, reviewed 9/2014. The policy included, but was not limited to:</p> <p>The facility shall utilize proper infection control and prevention when dealing with residents with Multiple Drug Resistant Organisms infections.....MDRO's are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents.....</p> <p>This Federal tag relates to Complaint IN00206694 and Complaint IN00204892.</p> <p>3.1-18(b)(1)</p>			

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary environment for 20 of 32 resident rooms observed. Dirt and debris was built up, rust was present, drywall was chipped, resident equipment was stored on the floor. (Room #153, Room #159, Room #149, Room #144, Room #141 Room #152, Room #124, Room #153, Room #158, Room #173, Room #176, Room #177, Room #178, Room #189, Room #193, Room #194, Room #197, Room #212, Room #134, Room #206)</p> <p>Findings include:</p> <p>1. On 8/17/16 at 10:39 a.m., Room #153 was observed. In the bathroom, the doorframe was observed to be rusted,</p>	F 0465	<p><u>F465Safe/Functional/Sanitary/Comfortable Environment</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Room #153: The bathroom doorframe was painted by maintenance and is free from rust. The drywall was repaired and repainted by maintenance and are free of chips. The bug was not found in the room. Pest control was called to inspect the facility and treat if indicated by the inspection. ·Room #159: The corners and edges along the wall in the bathroom have been cleaned and sanitized by housekeeping and are free of dirt, debris and buildup. ·Room #149: The corners and 	09/24/2016
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	<p>drywall was chipped, and a bug was observed to crawl underneath the cove base. On 8/24/16 at 10:12 a.m., Room #153 was observed again. In the bathroom, the doorframe was observed to be rusted, the drywall was chipped, and a plunger stored uncovered on the floor.</p> <p>2. On 8/16/16 at 11:56 a.m., Room #159 was observed. In the bathroom, dirt and debris was observed to be built up in the corners and along the edges of the wall. On 8/24/16 at 1:39 p.m., the same was observed.</p> <p>3. On 8/17/16 at 10:04 a.m., Room #149 was observed. In the bathroom, dirt and debris was observed to be built up in the corners and along the edges and a bed pan was stored uncovered on the floor. On 8/24/16 at 10:23 a.m., the bedpan was covered, but stored on the floor.</p> <p>4. On 8/17/16 at 9:40 a.m., Room #144 was observed. In the bathroom, the cove base was becoming detached from the wall and the drywall behind the toilet was chipped and cracking. On 8/24/16 at 10:15 a.m., the same was observed.</p> <p>5. On 8/16/16 at 12:12 p.m., Room #141 was observed. In the shower, towels were observed hanging up and an unlabeled and uncovered wash basin was stored on</p>		<p>edges in the bathroom have been cleaned and sanitized by housekeeping and are free of dirt, debris and buildup. The bed pan was removed and discarded of by housekeeping.</p> <ul style="list-style-type: none"> ·Room #144: Maintenance replaced the covebase cove base in the bathroom and repaired and repainted the drywall. ·Room #141: Housekeeping removed the towels from the shower and removed and discarded the wash basin that was storedn the back of the toilet. ·Room #152: The bed pan was removed fromthe back of the toilet and disposed of by housekeeping. ·Room#134: Maintenance replaced the cove base cove baseunder the sink and repaired and re painted the drywall. ·Room #206: The room was deep cleaned andsanitized by housekeeping and is odor free. ·Room #124: The room and bathroom weredeep cleaned by housekeeping and the floors are free of dirt and debris. Thestraw and facial tissues were discarded by housekeeping and the briefs wereremoved from the floor and stored appropriately. ·Room#153: The floor tech removed theplunger from the bathroom. Maintenance installed a toilet paper holder, replaced the bathroom cove base under the bathroom sink, and replaced the tilesby the air conditioner and outside the bathroom door. The 	

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	<p>the shower floor. On 8/24/16 at 1:43 p.m., the same was observed. The bathroom was shared by three residents.</p> <p>6. On 8/17/16 at 9:04 a.m., Room #152 was observed. In the bathroom, an uncovered and unlabeled bed pan was stored on the back of the toilet. On 8/24/16 at 10:13 a.m., an uncovered and unlabeled bedpan was stored on the bathroom floor. The bathroom was shared by three residents.</p> <p>7. On 8/16/2016 11:57 a.m., room #134 was observed to have the cove base under the sink coming off, and the edge of the wall by the sink had chipped drywall. The same was observed on 8/24/16 at 9:05 a.m.</p> <p>8. On 8/16/16 at 8:36 a.m., room #206 smelled of urine. The same was observe on 8/24/16 at 9:15 a.m.</p> <p>9. During an observation on 8/16/16 at 2:50 p.m., Room #124 was observed to have a wheelchair in the bathroom in front of the sink, a winged-back chair in the bathroom in front of the commode, dirt in the bathroom and bedroom floors, and dirt and debris along the edges and in the corners of the cove base. The same was observed on 8/23/16 at 9:57 a.m., except the wheelchair was in the hall.</p>		<p>corners and edges around the cove base inthe bathroom and resident room have been cleaned and sanitized by housekeepingand are free of dirt and debris.</p> <p>·Room#158: Housekeeping cleaned andsanitized the mattress and it is free of dirt and crumbs. The corners and edgeshave been cleaned and sanitized by housekeeping and are free of dirt anddebris. Maintenance capped the screws in the base of the commode. The floortech removed the plunger. Nursing made the bed with clean linens. The fly wasnot located in the room.</p> <p>·Room#176: The corners and edges aroundthe cove base have been cleaned and sanitized by housekeeping and are free of dirt and debris.</p> <p>·Room#177: The corners and edges aroundthe cove base have been cleaned and sanitized by housekeeping and are free of dirt and debris.</p> <p>·Room#178: The corners and edges aroundthe cove base have been cleaned and sanitized by housekeeping and are free of dirt and debris. The commode was re-caulked, the wood was repaired on the backof the entry door, and the sprayer was removed from the floor by maintenance.</p> <p>·Room#186: The corners and edges aroundthe cove base have been cleaned and sanitized by</p>	

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	<p>Also, an opened straw and a used facial tissue were observed under the resident's bed, an opened package of briefs were located on the floor in front of the closet, and an opened package of briefs were observed on the floor in front of the resident's night stand. The bathroom was observed to be used by the staff to obtain water for bathing the resident and also to disposed of the resident's urine.</p> <p>10. During an observation on 8/17/16 at 9:51 a.m., Room #153 was observed to have an uncovered plunger in the bathroom, chipped floor tiles by the air conditioning unit and outside of the bathroom door, dirt and debris along the edges and in the corners of the cove base, no toilet paper holder in the bathroom, and loose cove base under the sink in the bathroom. The same was observed on 8/24/16 at 11:22 a.m.</p> <p>11. During an observation on 8/17/16 at 9:19 a.m., Room #158 was observed to have a brown substance on the side of the resident's mattress, food crumbs on the resident's mattress, no toilet paper in the bathroom, an uncovered plunger in the bathroom, dirt and debris along the edges and in the corners of the cove base, uncapped and rusty screws on the base of the commode, and the bed had no linens. A fly was flying around the room. On</p>		<p>housekeeping and are free of dirt and debris. The plunger was removed by the floor tech. A toilet paperholder was installed by maintenance.</p> <ul style="list-style-type: none"> ·Room#189: The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. ·Room#193: The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. Housekeeping removed the washcloths from the sink and from the shared bathroom. Maintenance repaired the closet doors and replaced the tile behind the entry door. ·Room#193: Maintenance replaced the cove base in the bathroom and capped the screw on the left side of the toilet. The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. ·Room#194: The room was deep cleaned by housekeeping and the corners and edges are free of dirt and debris and the sink basin is free from foreign debris. The floor tech removed the plunger from the bathroom. Maintenance repainted the wall next to the toilet. Nursing staff discarded the toothbrush and replaced it with a new one. ·Room#197: The corners and edges around the cove base have been cleaned and sanitized by housekeeping and are free of dirt 		

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	<p>8/23/16 at 9:48 a.m., a piece of food was observed to be on the resident's floor, dirt and debris were observed along the edges and in the corners of the cove base, dirty linens were observed on the floor next to the bed, a piece of toilet paper was observed behind the commode on the floor, dirt was observed on the bathroom floor, and stool and urine was observed in the commode.</p> <p>12. During an observation on 8/17/16 at 10:57 a.m., Room #176 was observed to have dirt and debris along the edges and in the corners of the cove base. The same was observed on 8/23/16 at 9:42 a.m.</p> <p>13. During an observation on 8/17/16 at 11:01 a.m., room #177 dirt and debris were observed along the edges and in the corners of the cove base and a soiled, wet, blue washcloth was observed to be on the sink. The same was observed on 8/23/16 at 9:40 a.m. except the washcloth was gone.</p> <p>14. During an observation on 8/17/16 at 11:04 a.m., Room #178 was observed to have dirt and debris along the edges and in the corners of the cove base, the caulking around the base of the commode was stained with a brown substance, and the wood was scraped along the back of the entry door. The same was observed</p>		<p>and debris. Maintenance re-caulked the toilet, replaced the cove base in the bathroom and repaired the plastic cover in the entry door. The floor tech removed the plunger from the bathroom.</p> <p>·Room#212: The corners and edges have been cleaned and sanitized by housekeeping and are free of dirt and debris. The wall in the bedroom was painted by maintenance. The floor tech removed the plunger from the bathroom.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to be affected by the alleged deficient practice.</p> <p>·The ED/ designee will in-service all staff regarding a safe, comfortable and sanitary environment by 9/24/15.</p> <p>·The ED/designee will educate the housekeeping and maintenance staff on cleaning schedules and maintenance request.</p> <p>·Inspection of all rooms was conducted by ED/designee to identify areas of non-compliance. The identified areas will be corrected by 9/24/15.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p>				

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	<p>on 8/23/16 at 9:38 a.m. as well as a sprayer for the commode was observed to be lying in the bathroom floor.</p> <p>15. During an observation on 8/17/16 at 1:43 p.m., Room #186 was observed to have dirt and debris along the edges and in the corners of the cove base, an uncovered plunger in the bathroom, and there was no toilet paper on the holder in the bathroom. The same was observed on 8/23/16 at 10:24 a.m., as well as 3 opened rolls of toilet paper were observed in the bathroom floor, and the plunger was covered in a plastic bag.</p> <p>16. During an observation on 8/17/16 at 9:59 a.m., Room #189 was observed to have dirt and debris along the edges and in the corners of the cove base, floor tile was missing behind the entry door, and the closet doors were scraped. The same was observed on 8/23/16 at 10:28 a.m., as well as, a piece of broken wood with a point on it was located on the chest of drawers, a soiled wet washcloth was on the sink, and a soiled, dry washcloth was in the shared bathroom floor.</p> <p>17. During an observation on 8/16/16 at 2:37 p.m., Room #193 was observed to have loose cove base along the bathroom floor, dirt and debris along the edges and in the corners of the cove base, and an</p>		<p>The ED/ designee will in-service allstaff a safe, comfortable and sanitary environment by 9/24/15.</p> <p>Daily rounds will be conducted by theED/designee to ensure rooms are safe, comfortable and sanitary.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>TheED/designee will be responsible for the completion of the Laundry,Housekeeping, Cleaning Schedule Quality Assurance Tool weekly times 4 weeks,bi-monthly times 2 months, monthly times 4 and then quarterly until continuedcompliance is maintained for 2 consecutive quarters. The results of these audits will be reviewedby the QAPI committee overseen by the ED. If threshold of 100% is not achieved,an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>Dateof Compliance 09/24/2016</p>		

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	<p>exposed screw on the left side on the base of the commode. The same was observed on 8/23/16 at 10:20 except the commode screw was covered and an opened facial tissue was observed to be under the resident's bed on the floor.</p> <p>18. During an observation on 8/16/16 at 3:32 p.m., Room #194 was observed to have dirt and debris along the cove base, an unlabeled white toothbrush in a cup in the bathroom, an uncovered plunger in the bathroom, and paint chipped off the wall in the bathroom next to the commode. The same was observed on 8/23/16 at 10:45 a.m., except the plunger was covered with a plastic bag and a brown substance was on the sink around the basin. The bathroom was a shared bathroom.</p> <p>19. During an observation on 8/16/16 at 12:09 p.m., Room #197 was observed to have dirt and debris along the edges and in the corners of the cove base, the caulking on the commode had a brown stain on it, the plastic cover on the entry door is cracked and loose, and the cove base in the bathroom is loose. The same was observed on 8/23/16 at 10:26 a.m., as well as, a plunger was observed uncovered in the bathroom.</p> <p>20. During an observation on 8/17/16 at</p>			

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	<p>11:42 a.m., Room #212 was observed to have dirt and debris along the edges and in the corners of the cove base, the wall in the bedroom was marred, and the bathroom had an uncovered plunger in it. The same was observed on 8/23/16 at 10:37 a.m., as well as, the over bed table was dirty.</p> <p>On 8/24/16 at 1:18 p.m., the Housekeeping Supervisor indicated on a daily basis room cleaning included, but was not limited to: dusting, wiping down overbed tables, cleaning bathrooms, and sweeping and mopping the floor. The Housekeeping Supervisor indicated staff should notify him if resident equipment was in disrepair.</p> <p>On 8/24/16 at 1:34 p.m., the Housekeeping Supervisor provided the "Daily Guidelines" policy. The policy included, but was not limited to: Disinfect all furniture and surfaces and clean the floor.</p> <p>This Federal tag relates to Complaint IN00206694 and Complaint IN00204892.</p> <p>3.1-19(f)</p>			

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F 0514 SS=E Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and</p>	F 0514	<u>F514Records-</u>	09/24/2016

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	<p>record review, the facility failed to ensure documentation was complete and accurate for 4 of 38 residents reviewed during Stage 2 of the survey for documentation. Resident refusals, medication administration, colostomy care, and behaviors were not documented. (Resident M, Resident O, Resident U, Resident W)</p> <p>Findings include:</p> <p>1. On 8/22/16 at 8:56 a.m., Resident O's clinical record was reviewed. The most recent signed physician's recapitulation orders, undated, included, but was not limited to: Right lateral lower leg open area: cleanse with wound cleanser, apply small piece of calcium alginate and cover with dry dressing. Change every three days and as needed, dated 7/12/16.</p> <p>The July TAR (Treatment Administration Record) indicated Resident O had refused a dressing change on 7/18/16. The TAR further indicated Resident O had a dressing change on 7/23/16, 7/25/16, and 7/30/16. The TAR lacked any other documented refusals.</p> <p>On 8/22/16 at 9:16 a.m., the CEC (Clinical Education Coordinator) indicated Resident O sometimes refused dressing changes but it should be</p>		<p><u>Complete/Accurate/Accessible</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Documentation in the medical record that Resident M is provided ostomy care and all medications per physician orders. · Resident O is provided wound care per physician orders, with any refusal of care, along with notification of MD notification of refusal documented per policy. · Behavior tracking flowsheets are being utilized for Resident W for all exhibited behaviors, with documentation present on all shifts daily regarding presence or absence of behaviors and effectiveness of interventions. · Behavior tracking flowsheets are being utilized for Resident D for all exhibited behaviors, with documentation present on all shifts daily regarding presence or absence of behaviors and effectiveness of interventions. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · An was completed of all nursing documentation and 				

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	<p>documented on the back of the TAR.</p> <p>On 8/25/16 at 10:15 a.m., the Nurse Consultant provided the "Resident Refusal of Medications, Treatments" policy, revised 1/2015. The policy included, but was not limited to:.....The medication refusal will be documented by the nurse/QMA (Qualified Medication Aide) administering the medication or treatment by circling his/her initials on the MAR (Medication Administration Record)/TAR and documenting reason for refusal on the back or documenting the refusal in EMAR (Electronic Medication Administration Record)....</p> <p>2. On 08/17/16 at 2:02 p.m., Resident W was observed to be sitting in his wheelchair in the lounge crying. He indicated he was scared and wanted to know if his wife and family were ok. CNA #5 (certified nursing assistant) indicated that Resident W cries at times and is restless.</p> <p>On 08/24/16 at 10:40 a.m., Resident W was observed to have his shirt off in the lounge. CNA #6 was putting his shirt back on. CNA #6 was observed to then go to lunch. CNA #7 when queried, indicated that Resident W took his shirt off at times and cries. CNA #7 was further queried about interventions and</p>		<p>behavior tracking flowsheets by SSD/designee to ensuredocumentation of exhibited behaviors or lack of behaviors, as well aseffectiveness of interventions offered to prevent or manage behaviors was completedon all shifts.</p> <p>What measures will be put into placeor what systemic changes you will make to ensure that the deficient practicedoes not recur?</p> <ul style="list-style-type: none"> ·An audit will be completed of MARsfor all residents by DNS/designee daily to ensure accurate documentation ofmedication and treatment administration is completed. ·An in-service will be completed byDNS/designee by 09/24/2016 with all nursing staff regarding medication passprocedure. ·An audit will be completed daily ofall nursing documentation and behavior tracking flowsheets by SSD/designee toensure documentation of exhibited behaviors or lack of behaviors, as well aseffectiveness of interventions offered to prevent or manage behaviors iscompleted on all shifts. ·An in-service will be completed bySSD/designee by 09/24/2016 for all licensed staff regarding completion ofbehavior tracking flow sheets. <p>How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance</p>		

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	<p>activities provided to Resident W. CNA #7 indicated that she takes him to activities at times, but that the staff usually bring him back. CNA # 7 then took Resident W to the activity program.</p> <p>On 08/24/16 at 10:55 a.m., Resident W was observed to be sitting in the dining room where an activity was being conducted. The Activity Director was observed to be putting his shirt back on. The Activity Director then preceded with the activity being conducted.</p> <p>On 8/25/16 at 9:50 a.m., Resident W was observed to be sitting in front of the nurses station in his wheelchair crying.</p> <p>On 8/17/16 at 10:35 a.m., Resident W's clinical record was reviewed. His diagnoses included but were not limited to, Alzheimer's. Physician orders with a start date of 6/22/16 indicated that Resident W took Clonazepam (antianxiety) 0.25 mg (milligrams) two times a day. A care plan for behaviors dated 7/7/16 indicated that Resident W has episodes of severe restlessness including attempting to pull items off of the walls.</p> <p>Behavior flowsheets were in the clinical record for August 2016. There was a signature on August 23, all other dates</p>		<p>program will be put into place?</p> <ul style="list-style-type: none"> TheSSD/designee will be responsible for the completion of the Behavior Management QualityAssurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the QAPI committee overseen by the ED. If threshold of 100%is not achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible employee. TheDNS/designee will be responsible for the completion of the Medication Error QualityAssurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the QAPI committee overseen by the ED. If threshold of 100%is not achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible employee. TheDNS/designee will be responsible for the completion of the Medication Refusal QualityAssurance Tool weekly times 4 weeks, bi-monthly times 2 				

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	<p>before August 23, were not signed. There were no flowsheets for June or July 2016.</p> <p>On 8/24/16 at 8:24 a.m., the SSD (Social Service Director) indicated that behavior flowsheets were not formulated for Resident W until August 2016. His admit date to the facility was 6/22/16.</p> <p>3. On 8/18/16 at 8:57 a.m., a review of Resident D's clinical record was done. His diagnoses included, but were not limited, to bipolar disorder with psychotic features, dementia, mood disorder, and anxiety. He was admitted to the Living Moments Unit on 3/31/16, (dementia unit). A care plan with a start date of 11/18/15 indicated that resident D had a history of physical aggression towards others. A careplan dated 11/18/15 for behaviors can become fixated on others, and makes verbalizations. An approach indicated to monitor on a flowsheet every shift. Flowheets in the clinical record for July and August 2016 were not signed every day. July 3,4,5,6,7,14,15,23,24,25,27,29,31, August 1,6,7,8,9,11,12,13,14,17,19,20,21,22,23,24,25,26,27,28,29,30, and 31, were not signed.</p> <p>4. On 8/22/16 at 9:35 a.m.,Resident M's</p>		<p>months, monthly times 4and then quarterly until continued compliance is maintained for 2 consecutivequarters. The results of these audits willbe reviewed by the QAPI committee overseen by the ED. If threshold of 100% isnot achieved, an action plan will be developed. Deficiency in this practicewill result in disciplinary action up to and including termination ofresponsible employee.</p> <p>Dateof Compliance 09/24/2016</p>	

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	<p>clinical records were reviewed. An order dated 7/28/16 indicated to change Resident #M's colostomy bag every 3 days and as needed. The July Medication Administration Record order to change the colostomy bag, was not signed by nursing on July 4,7,10,13,22,25,or 28. An order for Keflex 500 mg by mouth 3 times a day for 10 days with a start date of 7/25/16. The medication was not signed as given on 7/26/16 at 8:00 p.m., 7/27/16 at 8:00 a.m., and 7/29/16 at 8:00 p.m. The medication was to be given until August 3, 2016. The August MAR was signed as given on August 4, and 5.</p> <p>On 8/24/16 at 10:19 a.m. the Director of Nursing Services Consultant indicated there was a problem with the documentation of the medication. He further indicated a pill count was done and it was determined it was a documentation problem not a medication error.</p> <p>On 8/25/16 at 10:15 a.m., the Director of Nursing Services provided a policy on the medication pass procedure. The policy indicated that medication administration will be documented on the Medication Administration Record.</p> <p>This Federal tag relates to Complaint</p>			

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	<p>dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past 5 (five) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:</p> <p>(1) meet the needs or preferences, or both, of cognitively impaired residents; and</p> <p>(2) gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by:</p>		<p>·A Memory Care Facilitator(MCF) is in place for the locked special dementia care unit.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents residing on the locked special dementia care unit have the potential to be affected by the alleged deficient practice.</p> <p>·The facility will ensure that the services of a designated MCF are maintained for the locked special dementia care unit.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·In absence of MCF, the SSD will assume responsibilities for locked special dementia care unit.</p> <p>·Staffing for the locked special dementia care unit will be reviewed daily by the ED/designee to ensure adequate staffing is present on the unit to meet the physical, emotional, and psychosocial needs of the residents residing on the unit.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·The MCF/designee will be responsible for the completion of the Memory Care Center Review</p>		

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	<p>Based on observation and interview, the facility failed to ensure the locked special dementia care unit had a Memory Care Facilitator for the unit.</p> <p>Findings include:</p> <p>During an observation on 8/16/16 at 9:00 a.m., and activity assistant and a CNA were observed on the Living Moments (a locked special dementia care unit) unit.</p> <p>During an interview on 8/16/16 at 9:10 a.m., LPN #3 indicated she oversaw the locked dementia unit as well as the Garden unit. LPN #3 indicated the facility usually provided 1 nurse and 2 CNAs to go between the locked dementia care unit and the Garden unit.</p> <p>During an interview on 8/23/16 at 11:26 a.m., the SSD (Social Service Director) indicated the locked dementia care unit did not have a Memory Care Facilitator. The SSD indicated the facility had been without a Memory Care Facilitator since November, 2015. The SSD indicated the facility had hired a new Memory Care Facilitator but she was not scheduled to begin working until next week.</p> <p>This State tag relates to Complaint IN 00204892.</p>		<p>Quality Assurance Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.</p> <p>Date of Compliance 09/24/2016</p>				

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