

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2013
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NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 12, 13, 14, and 18, 2013</p> <p>Facility number: 000310 Provider number: 155443 Aim number: 100288970</p> <p>Survey team: Betty Retherford, RN, TC Ginger McNamee, RN (February 12, 14, 18, 2013) Linn Mackey, RN Toni Maley, BSW Karen Lewis, RN,</p> <p>Census bed type: SNF/NF: 43 Total: 43</p> <p>Census payor type: Medicare: 2 Medicaid: 38 Other: 3 Total: 43</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<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.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Survey Review on or after 02/28/2013.</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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	Quality review completed on February 21, 2013 by Randy Fry RN.				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on clinical record review and interview, the facility failed to develop a comprehensive plan of care related to a resident's thigh wound and subsequent complications for 1 of 3 residents who met the criteria for pressure ulcer review. (Resident #10)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #10 was reviewed on 2/14/13 at 2:00 p.m.</p> <p>Diagnoses for the resident included,</p>	F000279	<p><b>F279 Develop Comprehensive Care Plans</b></p> <p>It is the practice of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p>	02/28/2013	

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	<p>but were not limited to, chronic severe rocker bottom charcot deformity bilaterally (of feet), chronic venous stasis, osteoarthritis, chronic lymphedema, and arteriosclerosis of the left leg.</p> <p>A physician's order, clarified on 10/24/12, indicated Resident #10 had a new order for a treatment to an area on her left thigh. The area was to be cleansed with skintegrity, non-stick gauze applied, and secured with tape daily for 10 days and as necessary for soilage or dislodgement.</p> <p>A physician's order, dated 10/24/12, also indicated the resident was to be referred to a dermatologist related to the area on the anterior thigh which was concerning for basal cell carcinoma. The order also indicated Cipro (an antibiotic) was to be given twice daily for 10 days for cellulitis.</p> <p>The clinical record indicated the resident was seen by the dermatologist for treatment on 11/15/12. A follow-up treatment of polysporin ointment and a bandaid was ordered. The area was later determined to be a squamous cell carcinoma. An order was received on 11/21/12 for Doxycycline (an antibiotic)100 mg twice daily for</p>		<ul style="list-style-type: none"> <li>· An audit was conducted of Resident #10's care plan to review and include current plan of care interventions based on assessments.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by this alleged deficient practice.</li> <li>· Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Resident care plans were audited and reviewed to include current plan of care.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· The interdisciplinary team reviews orders that were written the previous day during the clinical meeting.</li> <li>· During this review, the IDT reviews the plan of care by</li> </ul>				

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	<p>cellulitis of the thigh.</p> <p>The clinical record lacked any health care planning related to the area on the resident's left thigh requiring treatments to be given, a dermatology referral, cellulitis complications, and follow-up care.</p> <p>During an interview with the Administrator and DoN on 2/18/13 at 1:30 p.m., additional information was requested related to the lack of development of a comprehensive plan of care for the concerns noted above.</p> <p>During an interview on 2/18/13 at 2:45 p.m., the DoN indicated she had no further information to provide.</p> <p>The 7/1/11, policy for "Care Plans"</p>		<p>identifying the problems, goals and approaches for each individual resident.</p> <ul style="list-style-type: none"> <li>· Licensed nursing staff have been reeducated on 2/25/2013 to properly provide a plan of care for each individual resident based on need.</li> </ul> <p><b>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</b></p> <ul style="list-style-type: none"> <li>· The Director of Nursing or designee will observe and participate in the IDT morning review process.</li> <li>· A resident plan of care quality assurance audit tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter.</li> <li>· The Quality Assurance Committee will review the data. If threshold is not achieved, an action plan will be developed.</li> <li>· One on One reeducation and or disciplinary action may occur for noncompliance.</li> </ul> <p>Compliance date: 02/28/2013</p>		

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	<p>was provided on 2/18/13 at 2:25 p.m., by the Director of Nursing. The guidelines indicated "It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. The policy indicated a "Care Plan" contains resident problems/needs/strengths, resident goals and interdisciplinary approaches. The procedure indicated the following: "1. Each resident upon admission or a significant change of condition will be assessed by all disciplines (i.e., MDS [Minimum Data Set assessment] and other departmental assessment tools)...4. The interdisciplinary team along with the resident and/or family members will identify resident problems, needs and strengths. 5. For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable (i.e., walk from nurses station to room by the next review of care plan.) 6. Staff approaches are to be developed for each problem/strength need. When possible, more that one discipline per approach is to be documented on the care plan or ALL disciplines are responsible for that approach. 7. All goals and approaches are to be</p>			

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	<p>reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition. 8. Each departments' notes are to reflect a review of all appropriate care plan goals and approaches."</p> <p>3.1-35(a)</p>				

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F000280 SS=D	<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 clinical record review, observation, and record review, the facility failed to ensure each resident's comprehensive plan of care was reviewed and revised as needed to maintain continuity of care for 1 of 3 resident's reviewed who met the criteria for pressure ulcer review. (Resident #10)</p> <p>Findings include:</p> <p>1.) During a treatment observation on 2/13/13 at 1:30 p.m., completed by LPN #1, Resident #10 was noted to have small open areas on the top of the 3rd and 4th toes of the left foot.</p>	F000280	<p><b>F280 Right to Participate Planning Care-Revise CP</b></p> <p>It is the practice of this provider to review and revise each resident's plan of care as needed to maintain continuity of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <p>·An audit was conducted of Resident #10's care plan to review and include current plan of</p>	02/28/2013			

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	<p>The treatment was completed as ordered and a dressing was applied and dated to the areas.</p> <p>The clinical record for Resident #10 was reviewed on 2/14/13 at 2:00 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic severe rocker bottom charcot deformity bilaterally (of feet), chronic venous stasis, osteoarthritis, chronic lymphedema, and arteriosclerosis of the left leg.</p> <p>A health care plan problem, dated 10/22/12, indicated the resident had venous ulcers on the left 3rd and 4th toes. Approaches for this problem included, but were not limited to, assess wound site every shift, assess for signs or symptoms of infection, and follow facility protocols for wound measurement and documentation.</p> <p>A physician's order, clarified on 10/24/12, indicated Resident #10 was to receive the following treatment to the toe wounds:</p> <p>Cleanse area on left foot toes with skintegretity (3rd and 4th toes), apply non-stick gauze, secure with tape. Change every day times 10 days and as needed for soilage or</p>		<p>care interventions based on assessments for continuity of care.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by this alleged deficient practice.</li> <li>·Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide continuity of care. Resident care plans were audited and reviewed to include current plan of care.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <ul style="list-style-type: none"> <li>·The interdisciplinary team reviews orders that were written the previous day during the clinical meeting.</li> <li>·During this review, the IDT reviews the plan of care by identifying the problems, goals and approaches for each individual resident.</li> <li>·Licensed nursing staff have been reeducated on 2/25/2013 to properly provide a plan of care for each individual resident based on need.</li> </ul>				

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	<p>dislodgement.</p> <p>The treatment administration record (TAR) indicated the treatment was completed as ordered and stopped on 11/3/12.</p> <p>A physician's order, dated 12/19/12 indicated the resident had a new order for a treatment to the left 3rd and 4th toes. The treatment indicated the areas were to be rinsed with normal saline, pat dry, apply bacitracin ointment and dry sterile dressing. The treatment was to be done daily for 10 days or until resolved.</p> <p>The TAR indicated the treatment was done on December 19, 20, and 21, 2012 and refused the other 7 days. December 28th was the last day of any documented treatment attempt or refusal.</p> <p>A physician's order, dated 1/11/13, indicate a treatment had been re-ordered to the 3rd and 4th toes of the left foot. The treatment indicated the areas were to be cleansed with skintegrit, patted dry, bacitracin ointment applied, and covered with a gauze and secured with tape. The treatment was to be done every day and as needed for dislodgement.</p>				<p><b>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</b></p> <ul style="list-style-type: none"> <li>·The Director of Nursing or designee will observe and participate in the IDT morning review process.</li> <li>·A resident plan of care quality assurance audit tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter.</li> <li>·The Quality Assurance Committee will review the data. If threshold is not achieved, an action plan will be developed.</li> <li>·One on One reeducation and or disciplinary action may occur for noncompliance.</li> </ul> <p>Compliance date: 02/28/2013</p>		

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	<p>This treatment remained current at the time of the observation noted above on 2/13/13.</p> <p>The health care plan problem, noted above dated 10/22/12, lacked any information related to the status of the wounds following the first treatment ordered on 10/24/12. The health care plan problem lacked any information related to the need for toe treatments being reordered on 12/19/12 and 1/11/13. The health care plan lacked any information related to the resident refusing some of the treatments.</p> <p>During an interview with the Administrator and DoN on 2/18/13 at 1:30 p.m., additional information was requested related to the lack of revision of the health care plan following discontinuation of a treatment, reordering of a treatment, and resident refusals of treatment.</p> <p>During an interview on 2/18/13 at 2:45 p.m., the DoN indicated she had no further information to provide.</p> <p>The 7/1/11, policy for "Care Plans" was provided on 2/18/13 at 2:25 p.m.,</p>				

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	by the Director of Nursing. The guidelines indicated "It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. The policy indicated a "Care Plan" contains resident problems/needs/strengths, resident goals and interdisciplinary approaches. The procedure indicated the following: "1. Each resident upon admission or a significant change of condition will be assessed by all disciplines (i.e., MDS [Minimum Data Set assessment] and other departmental assessment tools)...4. The interdisciplinary team along with the resident and/or family members will identify resident problems, needs and strengths. 5. For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable (i.e., walk from nurses station to room by the next review of care plan.) 6. Staff approaches are to be developed for each problem/strength need. When possible, more than one discipline per approach is to be documented on the care plan or ALL disciplines are responsible for that approach. 7. All goals and approaches are to be reviewed and revised as appropriate			

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	<p>by a team of qualified persons after each assessment and upon significant change of condition. 8. Each departments' notes are to reflect a review of all appropriate care plan goals and approaches."</p> <p>3.1-35(d)(2)(B)</p>				

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F000309 SS=D	<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 clinical record review, observation, and record review, the facility failed to ensure wound care services were provided in a manner to promote continued healing for 1 of 3 residents reviewed who met the criteria for pressure ulcers review. (Resident #10)</p> <p>Findings include:</p> <p>1.) During a treatment observation on 2/13/13 at 1:30 p.m., completed by LPN #1, Resident #10 was noted to have small open areas on the top of the 3rd and 4th toes of the left foot. The treatment was completed as ordered and a dressing was applied and dated to the areas.</p> <p>The clinical record for Resident #10 was reviewed on 2/14/13 at 2:00 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic severe rocker bottom charcot deformity bilaterally (of feet), chronic venous</p>	F000309	<p><b>F 309 Provide Care/Services for Highest Well Being</b></p> <p>It is the practice of this provider that each resident receive 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 care plan.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <p>·An audit was conducted of Resident #10's care plan to review and include current plan of care interventions and treatments based on assessments and physician orders.</p> <p><b>How will you identify other residents having the potential to be affected by the same</b></p>	02/28/2013	

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	<p>stasis, osteoarthritis, chronic lymphedema, and arteriosclerosis of the left leg.</p> <p>A health care plan problem, dated 10/22/12, indicated the resident had venous ulcers on the left 3rd and 4th toes. Approaches for this problem included, but were not limited to, "assess wound site every shift," "assess for signs or symptoms of infection," and "follow facility protocols for wound measurement and documentation."</p> <p>A physician's order, clarified on 10/24/12, indicated Resident #10 was to receive the following treatment to the toe wounds:</p> <p>Cleanse area on left foot toes with skintegretity (3rd and 4th toes), apply non-stick gauze, secure with tape. Change every day times 10 days and as needed for soilage or dislodgement.</p> <p>The treatment administration record (TAR) indicated the treatment was completed as ordered and stopped on 11/3/12.</p> <p>The nursing notes and TAR lacked any assessment of the above noted wounds at the time the treatment was</p>		<p><b>deficient practice and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by this alleged deficient practice.</li> <li>·Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Resident care plans were audited and reviewed to include current plan of care.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <ul style="list-style-type: none"> <li>·The interdisciplinary team reviews orders that were written the previous day during clnical meeting.</li> <li>·During this review, the IDT reviews the plan of care by identifying the problems, goals and approaches for each individual resident in order to provide care necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</li> <li>·Licensed nursing staff have been reeducated on 2/25/2013 to properly provide a plan of care for each individual resident based on need and document accordingly</li> </ul>				

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	<p>stopped related to the status of healing. The clinical record lacked any "non-pressure ulcer monitoring sheets" completed for these areas documenting the status of the healing or non-healing of the wounds at the completion of the 10 day treatment.</p> <p>A physician's order, dated 12/19/12 indicated the resident had a new order for a treatment to the left 3rd and 4th toes. The treatment indicated the areas were to be rinsed with normal saline, patted dry, then apply bacitracin ointment and cover with a dry sterile dressing. The treatment was to be done daily for 10 days or until resolved.</p> <p>This order was transcribed to the TAR indicating the treatment was to be done for 10 days. The TAR did not indicate the treatment was to be done for 10 days or "until resolved." The TAR indicated the treatment was done on December 19, 20, and 21, 2012 and refused the other 7 days. December 28, 2012 was the last day of any documented treatment attempt or refusal.</p> <p>The nursing notes and TAR lacked any assessment of the above noted wounds at the time the treatment was stopped related to the status of</p>		<p>in the clinical record.</p> <ul style="list-style-type: none"> <li>·Physician orders will be reviewed and clarified if necessary to include plan of care needs for interventions or treatments for a specific time frame or until resolved.</li> </ul> <p><b>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</b></p> <ul style="list-style-type: none"> <li>·The Director of Nursing or designee will observe and participate in the IDT morning review process.</li> <li>·A resident plan of care quality assurance audit tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter.</li> <li>·The Quality Assurance Committee will review the data. If threshold is not achieved, an action plan will be developed.</li> <li>·One on One reeducation and or disciplinary action may occur for noncompliance.</li> </ul> <p>Compliance date: 02/28/2013</p>		

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	<p>healing. The clinical record lacked any "non-pressure ulcer monitoring sheets" completed for these areas documenting the status of the healing or non-healing of the wounds at the completion of the 10 day time period.</p> <p>The clinical record lacked any nursing notes from 12/20/12 through 1/10/13.</p> <p>A physician's order, dated 1/11/13, indicated a treatment had been re-ordered to the 3rd and 4th toes of the left foot. The treatment indicated the areas were to be cleansed with skintegrity, patted dry, bacitracin ointment applied, and covered with a gauze and secured with tape. The treatment was to be done every day and as needed for dislodgement. This treatment remained current at the time of the observation noted above on 2/13/13. Weekly wound measurements and monitoring were now being recorded.</p> <p>During an interview with the Administrator and DoN on 2/18/13 at 1:30 p.m., additional information was requested related to the lack of assessment and monitoring of the areas on the resident's toes as noted above.</p> <p>During an interview on 2/18/13 at</p>				

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	<p>2:45 p.m., the DoN indicated she had no further information to provide.</p> <p>The 7/1/11, policy for "Quality Assurance Skin Assessment" was provided by the Director of Nursing on 2/18/13 at 2:35 p.m. The guideline indicated "it is the intent of the facility we will monitor the residents' skin integrity regularly, document and treat as appropriate any identified skin conditions." The procedure indicated "...2. In addition to daily observations of the resident's skin by the nursing staff; A Licensed Nurse will be assigned to complete an assessment of every resident's skin at least weekly. 3. Document on the appropriate Skin Condition Monitoring Report/Pressure Sore Report, an assessment of those areas identified as requiring treatment or monitoring. Utilize a separate sheet for each identified area. 4. Notify the resident's physician as appropriate. 5. Initiate treatment to identified skin conditions per treatment protocol and physician's order, and incorporate changes on the care plan as needed. 6. All residents with wounds or pressure ulcers will have a weekly assessment of the area and documentation completed on the appropriate sheet...."</p>				

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	3.1-37(a)				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure interventions identified in the resident's plan of care were in place to help prevent unassisted ambulation and potential falls for 2 of 3 residents reviewed who met the criteria for falls. (Resident #63 and #53)</p> <p>Findings include:</p> <p>1.) During an observation on 2/18/13 at 9:00 a.m., Resident #63 was up in her wheelchair in the activity room. There was no personal clip alarm in place on her wheelchair.</p> <p>Following notification that the alarm was not in place on 2/18/13 at 9:05 a.m., LPN #1 instructed CNA #2 to obtain the personal alarm and put it on the wheelchair and attach it to the resident's clothes.</p> <p>On 2/18/13 at 9:08 a.m., CNA #2 entered the resident's room and obtained the personal alarm from the resident's bedside table and put it on</p>	F000323	<p><b>F323 Free of Accident Hazards/Supervision/Devices</b></p> <p>It is the practice of this provider to utilize interventions identified in the resident's plan of care that are in place to help prevent unassisted ambulation and potential for falls.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <p>·An audit was conducted of Resident #63 and #53 plan of care to review interventions for appropriateness based on the resident's assessment and care needs.</p> <p>·The alarms for Residents #63 and #53 were checked for proper placement and functioning.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p>	02/28/2013			

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	<p>the resident's wheelchair.</p> <p>The clinical record for Resident #63 was reviewed on 2/13/13 at 10:45 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, dementia with psychotic features, advanced Alzheimer's disease, debility, and anemia.</p> <p>A health care plan problem, dated 10/15/12 and last reviewed on 1/28/13, indicated the resident was at risk for falls related to debility, Alzheimer's disease, and other health related issues. Interventions for this problem included, but were not limited to, the use of a personal alarm.</p> <p>A fall risk assessment, completed on 1/17/13, indicated the resident had a score of 14. The assessment indicated a score above 10 was a high risk for falls.</p> <p>A nursing note, dated 1/17/13 at 3:15 p.m., indicated the nurse was called to Resident #63's room by the overhead page. The resident was found on the floor near the foot of her bed. The resident's wheelchair was nearby. No injuries were noted. The note lacked any information related to</p>		<p>·All residents that require interventions to help prevent unassisted ambulation and potential for falls have the potential to be affected by this alleged deficient practice.</p> <p>·Each resident identified with interventions for alarms were checked for proper placement and functioning.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>·The interdisciplinary team reviews accidents and incidents at the IDT clincial meeting for cause and proper interventions.</p> <p>·Nursing staff have been reeducated on 2/25/2013 for the proper placement and functioning of resident personal alarms.</p> <p>·Disciplinary action was taken based on the identification of the alarms of residents #63 and #53 not being in place as noted in the resident's plan of care to aide in preventing unassisted ambulation and potential falls.</p> <p><b>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</b></p> <p>·The Director of Nursing or designee will observe and</p>				

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	<p>whether the resident's personal alarm was in place and sounding at the time of the fall.</p> <p>A fall investigation report, provided by the DoN on 2/14/13 at 9 a.m., indicated the resident was found on the floor in her room. The report indicated she had been sitting in her wheelchair prior to the fall. The report indicated the resident's personal alarm had not been attached and was not sounding at the time of the fall.</p> <p>2.) During an observation with LPN #3 on 2/18/13 at 9:49 a.m., Resident #53 was in her wheelchair in her room and the seatbelt alarm was not latched. LPN #3 indicated the resident was to have the seatbelt alarm on while up in the wheelchair.</p> <p>The clinical record for Resident #53 was reviewed on 2/14/13 at 7:43 a.m.</p> <p>Diagnoses for Resident #53 included, but were not limited to, dementia, osteoporosis, osteoarthritis, kyphosis, and anxiety.</p> <p>A quarterly Minimum Data Set assessment, dated 12/7/12, indicated the resident was severely cognitively impaired, and required extensive</p>		<p>participate in the IDT morning review process to evaluate accidents and incidents for proper interventions.</p> <ul style="list-style-type: none"> <li>·A resident personal alarm quality assurance audit tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter.</li> <li>·The Quality Assurance Committee will review the data. If threshold is not achieved, an action plan will be developed.</li> <li>·One on One reeducation and or disciplinary action may occur for noncompliance.</li> </ul> <p>Compliance date: 02/28/2013</p>				

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	<p>assistance of the staff for transfers, bed mobility, and toileting.</p> <p>A fall risk assessment, dated 12/7/12, indicated the resident had a score of 12. The assessment indicated a score above 10 indicated the resident was at risk for falls.</p> <p>A health care plan problem, dated 9/23/11, and last updated on 2/15/13, indicated Resident #53 was at risk for falls due to multiple health issues including dementia, osteoarthritis and weakness. Approaches for this problem included, but were not limited to, resident having an alarm on while in the chair.</p> <p>A "care plan guide" provided by the Director of Nursing on 2/18/13 at 8:20 a.m., indicated Resident #53 was to have a wheelchair seat belt alarm. The DoN indicated the staff were to use the "care plan guides" for resident care information including, but not limited to, transfers, alarms, and toileting.</p> <p>3.1-45(a)(2)</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure the stove drip pan was clean and free of residue and dishes were dried in manner to ensure thorough air drying. This deficient practice had the potential to impact 41 of the facility's 43 residents who ate food prepared in the kitchen.</p> <p>Findings include:  During a 2/12/13, 8:25 a.m., initial kitchen sanitation tour the following concerns were observed:</p> <p>a.) The drip pan, located under eye burners on the stove, had a thick sticky dark brown residue all over the bottom. In the residue were particles of food items.</p> <p>b.) Dishes were drying on the counter of the 3 compartment sink. The dishes were resting flat against the counter top. This drying method did not allow air under the equipment for</p>	F000371	<p><b>F 371 Food Procure, Store/Prepare/Service-Sanitary</b></p> <p>It is the practice of this provider to store, prepare, distribute and serve food under sanitary conditions.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <ul style="list-style-type: none"> <li>The drip pan, located, under eye burners was immediately removed and cleaned by the dietary manager.</li> <li>The dishes were immediately removed, rewashed, resanitized and placed on a drying rack for proper ventilation.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what</b></p>	02/28/2013			

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	<p>air drying. The dishes included 4 steam table pans and three scoops.</p> <p>During a 2/12/13, 8:40 a.m. interview , the Dietary Manager indicated the drip pan needed cleaned. She additionally indicated she herself had washed the steam table pans and placed them on the counter to dry. She indicated she had not considered the fact that air could not get under the pans for air drying. She indicated she should have used a drying rack.</p> <p>During a 2/18/13, 1:10 p.m., interview the Dietary Manager indicated on 2/12/13 forty one residents were eating meals prepared in the facility's kitchen.</p> <p>Review of an undated, untitled, facility dietary cleaning form, which was provided by the Dietary Manager on 2/18/13 at 1:30 p.m., indicated the Day Cook and Night Cook were each responsible for checking the "Drip pan under eye burner" during their shift.</p> <p>3.1-21(i)(3)</p>		<p><b>corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by this alleged deficient practice.</li> <li>Dietary personnel was reeducated immediately and on 2/28/2013 on the updated cleaning schedule which includes the drip pan and proper drying of dishes.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <ul style="list-style-type: none"> <li>The cleaning schedule was revised on 2/12/2013 to include the drip pan to be cleaned by the day and night cooks.</li> <li>Proper equipment for drying was identified and in use for the drying of dishes.</li> </ul> <p><b>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</b></p> <ul style="list-style-type: none"> <li>The Dietary Manager or designee will observe for proper dietary methods being used in the</li> </ul>				

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			<p>kitchen to promote a sanitary environment.</p> <ul style="list-style-type: none"> <li>A routine kitchen rounds will be utilized weekly x 4, monthly x 2 and quarterly thereafter.</li> <li>The Quality Assurance Committee will review the data. If threshold is not achieved, an action plan will be developed.</li> <li>One on One reeducation and or disciplinary action may occur for noncompliance.</li> <li>Compliance date: 02/28/2013</li> </ul>		

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F000465 SS=C	<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 and interview, the facility failed to ensure 19 out of 26 rooms, 1 of 1 dining room, and 2 of 2 shower rooms were clean and in good repair. This deficient practice had the potential to effect 43 out of 43 residents residing in the building.</p> <p>Findings include:</p> <p>During the stage 1 resident room reviews on 2/12/13 between the hours of 9:00 a.m. and 4:30 p.m., the following concerns were observed:</p> <p>In the bedroom of room 302, bare nails were noted in the walls. The walls were scuffed up with dark marks. The cove base was loose and dirty. In the bathroom, a dark substance was on the floor near the shower. The wall paper was coming off the wall over the sink and next to soap dispenser.</p> <p>In the bathroom of room 305, which was shared with room 307, the walls on both sides of the sink were rough to the touch. The bathroom smelled of urine. During additional</p>	F000465	<p><b>F 465</b> <b>Safe/Functional/Sanitary/Comfortable Environment</b></p> <p>It is the practice of this provider to a safe, functional, sanitary and comfortable environment for residents, staff and the public.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <ul style="list-style-type: none"> <li>• Areas identified during survey were acknowledged and immediate corrections were started.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>• All residents, staff and the public have the potential to be affected by this alleged deficient practice.</li> </ul>	02/28/2013	

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	<p>observations on 2/13/13 at 10 a.m. and 2/14/13 at 2:00 p.m., the bathroom continued to have a urine odor.</p> <p>In the bedroom of 306, the finish was worn off the bedside tables exposing a porous surface . The finish was worn off the foot board of bed A exposing a porous surface. The closet unit had the finish and the veneer missing on the corner of the unit. The bottom drawer was off the track and/or broken. A dark substance was noted in the corner behind the door. In the bathroom which was shared with room 307, the tile had a dark stain under the toilet.</p> <p>In the bathroom of room 309, which was shared with room 311, the sink was pulled away from the wall exposing bare dry wall above the sink. Scrapes were noted at the bottom of both interior bathroom doors. The paint was scraped off the doorframe by the toilet. A gray black area was noted under the toilet. A strong urine odor was noted in the room. During additional observations on 2/13/13 at 10 a.m. and 2/14/13 at 2:00 p.m., the bathroom continued to have a urine odor.</p> <p>In room 310, a section of wall paper</p>		<ul style="list-style-type: none"> <li>A thorough round of the facility was completed and items identified were addressed by the maintenance director.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <ul style="list-style-type: none"> <li>Routine preventative maintenance rounds will be utilized to identify areas that need to be addressed by maintenance.</li> <li>Maintenace request forms are located at the nurse's station and by the maintenace director's office for residents, staff or visitors to complete if an item is identified as needing the attention of the maintenance director.</li> <li>Items that have been identified or addressed will be reviewed at the morning stand up meeting.</li> </ul> <p><b>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</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director or designee will observe and</li> </ul>				

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	<p>was torn away from the wall over the bed . In the bathroom, which was shared with room 312, the wall behind the toilet had water damage directly above the cove base.</p> <p>In the bathroom of room 403, there was an unpainted section of wall where a towel dispenser had previously been located.</p> <p>In room 406, the wall above the headboard had a section of missing wall paper. In the bathroom, which was shared with room 404, there was an unpatched and unpainted area noted on the wall where a towel dispenser had previously been located. There was a dark residue built up around the bathroom door frame and in the corner.</p> <p>In the bathroom of room 407, which was shared with room 409, there was an unpainted area on the wall where a towel dispenser had previously been located. The tile under the sink was discolored. The bathroom door on the side of room 407 had a large scrape noted across the entire door. A dark residue was noted in the corners of the bathroom.</p> <p>In the bathroom of room 410, which was shared with room 408, an area</p>		<p>participate in weekly rounds of the facility premises to identify items that need to be addressed.</p> <ul style="list-style-type: none"> <li>A preventative maintenance quality assurance audit tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter.</li> <li>The Quality Assurance Committee will review the data. If threshold is not achieved, an action plan will be developed.</li> <li>One on One reeducation and or disciplinary action may occur for noncompliance.</li> <li>Compliance date: 02/28/2013</li> </ul>		

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	<p>by the sink was patched but not painted. There was a build up of dark debris around the bathroom door frame edges and in the corners. The non-skid floor strip was loose in the front of the toilet.</p> <p>In the bathroom of room 411, which was shared with room 413, the bathroom had a slight urine smell. The door frames were knicked and there was dark residue in the corners of the room.</p> <p>In the bathroom of room 412, which was shared with room 414, the wall beside the bathroom sink was patched and not painted. The bathroom door frames were scuffed and there was a dark residue in the corners of the door frames.</p> <p>During the environmental tour on 2/14/13 at 2:00 p.m., with the Maintenance Supervisor in attendance, the following concerns were noted:</p> <p>In the North Shower Room #1, there were six, two by two tiles, and a four by four tile broken in the shower stall. There was a dark substance around the edge of the shower stall.</p> <p>In the North Shower Room #2, there</p>						

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	<p>was a 21 inch by 21 inch area of rough unfinished cement around the drain in the center of the shower room.</p> <p>During the conclusion of the environmental tour conducted on 2/18/13 at 9:30 a.m., with the Maintenance Supervisor in attendance, the following concern was noted:</p> <p>The back wall of the dining room had loose and/or peeling wall paper.</p> <p>During an interview on 2/14/13 at 2:30 p.m., the Maintenance Supervisor indicated there were no current plans to remodel the above areas.</p> <p>3.1-19(f)</p>				