STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENCROFT HEALTHCARE	1225 GREENCROFT DR GOSHEN, IN 46527

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 5, 6, 7, 10, 12, 13, and 14, 2014. Facility number: 000112 Provider number: 155205 AIM number: 100288710 Survey team: Julie Wagoner, RN, TC Deb Kammeyer, RN Diana McDonald, RN Lora Swanson RN (November 5, 6, 7, 10, 13 and 14, 2014) Census bed type: SNF: 18 SNF/NF: 171 Total: 189 Census payor type: Medicare: 18 Medicaid: 119 Other: 52 Total: 189 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F000000	**F 000 Initial Comments** This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a desk review of this Plan of Correction.	

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

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

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	Quality Review completed on November 22, 2014, by Brenda Meredith, R.N.			
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his			

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	designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interviews, the facility failed to ensure 1 of 3 allegations of abuse was thoroughly investigated and reported timely. This allegation involved discharged Resident #300. Finding includes: A review of an allegation of verbal and physical abuse, provided by the administrator, was conducted on 11/13/14 at 1:30 P.M. The allegation indicated the following: Discharged resident #300 expressed an allegation of abuse involving Employee #33, an LPN. The documentation indicated on 05/03/14, Resident#300 reported to CNA #34 an allegation which indicated the nurse had yelled at him and handled him roughly during a transfer. The CNA indicated she had reported the allegation of abuse to nursing administration. She indicated she did not report the allegation to her immediate supervisor because the allegation was against LPN #33. There was no follow up regarding the concern documented until 05/05/14 and the	F000225	**F 225** Facility uses Abaqis software program to monitor resident satisfaction, as well as the 24-hour report and management walking rounds. Issues/concerns identified are investigated and address/reported in a timely way as appropriate. All staff members were in-serviced and re-educated on Abuse reporting policy (Attachment A) to notify the immediate supervisor of any complaints immediately. The supervisor will immediately notify the Administrator or designee if Administrator is not available. Nursing staff will communicate any alleged abuse/complaints to their NTL or designee immediately. The NTL or designee will be responsible to notify the Administrator of any complaints. On weekends and holidays all staff will report to nurse on-call, who will immediately notify the Administrator. The DON, ADON or designee will review/audit the 24-hour report sheets daily for complaints from residents. The Administrator and/or designee will initiate appropriate reporting, investigation, and interventions from protection from	12/10/2014

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	allegation was not reported to State until 05/06/14. During an interview on 11/13/14 at 2:00 P.M., the administrator indicated the report had not been sent timely because she had not been notified timely of the allegation. She indicated LPN #33 had retired and was no longer employed at the facility. She indicated Resident #300 had also discharged. The Administrator indicated she did not know with whom the CNA had conversed with per her initial report on 05/03/14. She indicated she also was unsure if LPN #33 was immediately suspended when the allegation was voiced. During an interviewed, conducted on 11/13/2014 at 2:24 P.M., the DON (Director of Nursing), indicated he was informed on Sunday evening, 05/04/14, of the incident. He indicated he was not notified until 05/04/14 when he read an email sent by Employee #32, the unit secretary for CNA #34. He indicated he shared the information with the ADON (Assistant Director of Nursing) because she was familiar with the resident and his wife. The DON indicated no one notified him regarding the allegation even though he was the weekend supervisor, except via the email which he did not read until 05/04/14. He indicated the staff should		harm (Attachment B). These will be communicated to the physician, family and staff. This will be ongoing. The DON or designee will report findings of QAPI committee for review and recommendations. Alleged date of compliance 12/10/2014	

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	have called him. He indicated he was on call but came in to the facility for 4 hours on 05/04/14 and happened to read his email. The DON indicated the ADON completed the investigation on 05/05/14 (Monday) and then the Administrator reported the allegation on 05/06/14. The DON indicated LPN #33 was not on the schedule on 05/06/14 as she only worked part time. The DON indicated the nurse accused of abuse was not sent home immediately as he was not notified of the allegation timely. The investigation documentation, completed by the ADON on 05/06/14, did not include statements or documentation of interviews with other staff working with LPN #33, including the other staff member who would have been present during the stand up lift transfer for Resident #300. There was a statement from CNA #34. There were no statements from other alert and oriented residents who were cared for by LPN #33 during the timeframe of the allegation. The DON was unsure if the ADON had completed any further investigation and no more information was provided regarding the allegation of abuse. The facility policy and procedure, titled Abuse - Investigation of Abuse and Protection of the Resident, dated 11/99			

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	and updated on 08/06, and provided by the Administrator as the current policy on 11/13/14 at 9:00 A.M. included the following: "1. Staff concerns regarding abuse, neglect or involuntary seclusion will be recorded on an incident report form and forwarded to the administrator or designee.... 2. Resident, family or visitor concerns regarding abuse, neglect, involuntary seclusion or misappropriation of property will be recorded on a grievance/complaint report form and forwarded to the administrator or designee. 3. If a family member and/or visitor is suspected, the physician, Adult Protective Services (APS), Indiana State Department of Health (ISDH) and the LTC (Long Term Care) 4 Ombudsman will be notified within 24 hours. 4. Staff incidents that involve abuse, neglect, involuntary seclusion and/or misappropriation of resident property will be investigated as follows: a. The staff member involved will be immediately removed from working with residents. The employee may be suspended without pay for up to five days, pending an investigation. b. In the event the allegation involves a supervisory level employee, the investigation will be conducted by a			

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	member of senior management for the facility...." 3.1-28(c) 3.1-28(d)			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to ensure staff followed the facility policy and procedure regarding abuse for 1 of 3 allegations of abuse reviewed. This allegation involved discharged Resident #300. Finding includes: A review of an allegation of verbal and physical abuse, provided by the Administrator, was conducted on	F000226	**F 226** There have been no further complaints from resident #300. Resident #300 and wife have voiced high satisfaction with care prior to and after concerns. Nurse #33 had personally apologized to resident and wife. Nurse #33 has retired from Greencroft. Facility used the Abaqis software program to monitor resident satisfaction, as well as the 24-hour report and management walking rounds. Issues/concerns identified	12/10/2014

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	11/13/14 at 1:30 P.M. The allegation indicated the following: Discharged Resident #300 expressed an allegation of abuse involving Employee #33, an LPN. The documentation indicated on 05/03/14, Resident #300 reported to CNA #34 an allegation which indicated the nurse had yelled at him and handled him roughly during a transfer. The CNA indicated she had reported the allegation of abuse to the nursing administration. She indicated she did not report the allegation to her immediate supervisor because the allegation was against LPN #33. There was no follow up regarding the concern documented until 05/05/14, when the DON read an email regarding the allegation. The allegation was not reported to the State and other required entities until 05/06/14. The Administrator was not notified of the allegation until 05/06/14. During an interview, on 11/13/14 at 2:00 P.M., the Administrator indicated the report had not been sent timely because she had not been notified timely of the allegation. She indicated she also was unsure if LPN #33 was immediately suspended when the allegation was voiced. During an interviewed, conducted on 11/13/2014 at 2:24 P.M., the DON		are investigated and address/reported in a timely way as appropriate. The Abuse Investigation Policy was reviewed and revised (Attachment A-1). All staff members were in-serviced and reeducated on Abuse reporting policy to notify the immediate supervisor of any complaints immediately (Attachment A). The supervisor will immediately notify the Administrator or designee if Administrator is not available. Nursing staff will communicate any alleged abuse/complaints to their NTL or designee immediately. The NTL or designee will be responsible to notify the Administrator of any complaints. On weekends and holidays all staff will report to nurse on-call, who will immediately notify the Administrator. The DON, ADON or designee will review/audit the 24-hour report sheets daily for complaints from residents. The Administrator and/or designee will initiate appropriate reporting, investigation, and interventions from protection from harm. These will be communicated to the physician, family and staff. This will be ongoing. # An investigation using the facility's incident report will be used to document the event within 24 hours. If the event investigation cannot be completed immediately, the report will be submitted to appropriate agencies as an initial	

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	(Director of Nursing), indicated he was informed on Sunday evening, 05/04/14, of the incident. He indicated he was not notified until 05/04/014, when he read an email sent by Employee #32, the unit secretary for CNA #34. He indicated he shared the information with the ADON (Assistant Director of Nursing) because she was familiar with the resident and his wife. The DON indicated no one notified him regarding the allegation even though he was the weekend supervisor, except via the email which he did not read until 05/04/14. He indicated the staff should have called him. The facility policy and procedure, titled Abuse - Investigation of Abuse and Protection of the Resident, dated 11/99 and updated on 08/06, and provided by the Administrator as the current policy on 11/13/14 at 9:00 A.M. included the following: "1. Staff concerns regarding abuse, neglect or involuntary seclusion will be recorded on an incident report form and forwarded to the administrator or designee.... 2. Resident, family or visitor concerns regarding abuse, neglect, involuntary seclusion or misappropriation of property will be recorded on a grievance/complaint report form and forwarded to the administrator or		report. A follow-up report will be completed within the five-day ISDH window. Supervisory staff were in-serviced and re-educated of the investigative protocol for abuse (Attachment C). The DON or designee will report findings to QAPI committee for review and recommendations. Alleged date of compliance 12/10/2014.	

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	designee. 3. If a family member and/or visitor is suspected, the physician, Adult Protective Services (APS), Indiana State Department of Health (ISDH) and the LTC (Long Term Care) 4 Ombudsman will be notified within 24 hours. 4. Staff incidents that involve abuse, neglect, involuntary seclusion and/or misappropriation of resident property will be investigated as follows: a. The staff member involved will be immediately removed from working with residents. The employee may be suspended without pay for up to five days, pending an investigation. b. In the event the allegation involves a supervisory level employee, the investigation will be conducted by a member of senior management for the facility...." 3.1-28(a)			
F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF			

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	EACH RES The facility must provide for an ongoing 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. Based on observation, record review, and interviews, the facility failed to ensure individualized activities were provided for 2 of 3 cognitively impaired residents reviewed for activities. (Resident #8 and #213) Findings include: 1. The clinical record for Resident #8 was reviewed on 11/06/14 at 12:19 P.M. Resident #8 was admitted to the facility, on 07/29/14, with diagnosis, including but not limited to, paralysis agitans, hypertension, hyperlipidemia, diabetes, dementia, depressive disorder, chronic kidney disease, insomnia, and personal history of a fall. An Activity interest inventory, completed on 12/12/13, indicated the resident had a past interest in baking, cooking, canning, computers, singing, and sewing/needle work. The inventory indicated the resident was no longer interested due to her cognitive issues. The resident had a current interest in books, newspaper, and magazines. She was documented as	F000248	**F 248 Activities Meet Interests/Needs** Activity needs of interest for residents #8 and #213 were reviewed. They have magazines, and current newspapers for their disposal. Neither resident suffered or exhibited any signs of psychosocial distress. The care plans of resident #8 and #213 were reviewed. All resident care plans were reviewed by activities and nursing staff to make sure activity needs were met per their individualized care plan. Staff will document via the Point of Care Charting system activity approach and outcome for resident on 1:1 and sensory stimulation programming. The supplies needed for these programs are available. Activities and nursing staff were in-serviced and	12/10/2014

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	being an introvert but enjoyed being with people. The resident was affiliated with a church and worked as a secretary in the past. She also loved to travel. An activity assessment, completed on 08/08/14, indicated the resident was confused at times, forgetful, needed reminders, could self initiate reading in large print, had lifelong interests of creating Christmas gifts for resident, music interests - hymn and classical in room and music programs. The assessment indicated they would provide 1:1 support, socialization, and encouragement visits. The assessment further indicated it was very important to the resident to have reading materials, keep up with the news, and participate in religious services. It was somewhat important for the resident to listen to music and do favorite activities. The resident also requested and was provided knitting needles and yarn. The assessment review for activities, dated 11/06/14, indicated the resident had experienced no significant changes in her activity levels, and declined most invitations to activities. The note indicated 1:1 support and encouragement visits would continue. The note also indicated the "highlights" were church (1) Evening fellowship (1), music		re-educated on accommodating residents needs while in their rooms and encourage all residents to participate in the activity of their choice (Attachment D). The Life Enhancement Coordinator or designee will monitor the implementation of activity interventions weekly using the activity charting and the Point of Care Charting system. Quarterly activity care plans are reviewed and revised as needed by the Life Enhancement Coordinator or designee and reported to the Social Service Director weekly. The Social Service Director or designee will submit a summary of findings to QAPI committee quarterly for review and recommendations. Alleged date of compliance 12/10/2014.	

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	programming (2), outside time (1), sing a long (1), and visitors - 2. The care plan related to activities, completed on 08/18/14 and current through 02/06/15, indicated the resident was at the facility due to declining health and recent falls. The resident' s cognition had also "suffered." The goal was for the resident to be accepting of encouragement towards group and nongroup activities of her choice/preferences The intervention was to provide encouragement towards activities available and reminders. During the survey on 11/07/14 and 11/08/14 from 9:30 A.M. - 3:00 P.M., Resident #8 was not observed to have attended any activity. She was noted to spend a majority of the day time hours in her darkened room. Resident #8 was noted to be in the bathroom in her room on 11/10/2014 10:47 A.M. Her brother was in the room to visit and indicated she was in the restroom. Resident #8 was observed, on 11/10/2014 at 2:32 P.M., in her darkened room, sitting on the side of the bed, awake. She was holding what looked like a greeting card but was not reading it. She did not			

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	seem to remember her brother visiting in the morning. Resident #8 was observed, on 11/12/2014 at 9:19 A.M., in a darkened room with the privacy curtain pulled around her. The resident was in her bed awake with 3 blankets covering her. She indicated she had a good breakfast and was not cold. Resident #8 was observed, on 11/12/2014 10:15 A.M., in her bed asleep with the privacy curtain pulled around her side of the room. She was not observed out of her room from 9:19 A.M. - 10:15 A.M. Resident #8 was observed, on 11/12/2014 at 1:54 P.M., in her room in the bathroom. She was not on the country ride activity. Resident #8 was observed, on 11/12/2014 at 2:25 P.M., seated in a side chair in her room. The light was on but there was no television or radio playing in her room. Resident #8 was observed on 11/13/2014 at 9:28 A.M., seated in the dining room drinking a cup of coffee. The resident was dressed and awake. She could not state if she had already eaten her breakfast. Resident #8 was observed, on 11/13/2014			

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	at 9:45 A.M., still seated in the Patio Dining Room now dozing with her cup of coffee on the table in front of her. At 11/13/2014 at 9:46 A.M., dietary staff were overheard asking her if she was all done and took her coffee cup and other glasses from the table back to the kitchen area. Resident #8 was observed, on 11/13/2014 at 9:58 AM, propelling herself with a rolling walker from the dining room back to her room and straight into the bathroom. Resident #8 was observed, on 11/13/2014 at 10:30 A.M, standing in her room by her dresser looking at some papers on her dresser. Resident #8 was observed, on 11/13/2014 at 2:24 P.M., lying in her bed with her right leg off the side of the bed. The resident did not know what the Birthday party was about, said it was not her birthday. When asked if she would have desired to go to the party she indicated she was already in bed and was going to take a nap. The Activity schedule for 11/12/14 was as follows: 9:30 A.M. Sing with Sue in the South unit dining room			

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	10:30 A.M. Exercises in the South Unit dining room 1:30 P.M. - Country Ride 6:00 P.M. - Massage in the North unit/East West unit The Activity schedule for 11/13/14 was as follows: 9:30 A.M. Exercises in the South Unit Dining room 10:00 A.M. Bible Study in the South Unit Dining room 2:00 P.M. Birthday Party in the Meeting House 6:30 P.M. 1st Baptist Church service in the Meeting House The Activity Participation logs for Resident #8, provided by the Activity Director on 11/14/14 at 10:45 A.M., indicated from 11/07/14 - 11/13/14, Resident #8 had attended a 10 minutes music activity, had selected candy off of a roving candy cart, had accepted cookies off of a roving cart, and had accepted a 5 minute 1:1 daily visit from the activity director. The resident had refused invitations to exercises, resident council, and Bingo. There were no other activities documented for Resident #8. During an interview, on 11/14/14 at 10:45 A.M, the Activity Director indicated Resident #8 was "quite			

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	difficult" and he just "can't quite find a scenario [activity]." He indicated the resident would sit for a long time in the Dining room on her unit, but there were no activities provided on the Gables unit except a couple times a week in the evening. The Activity Director did not indicate any attempt at activities in her room or in the dining room, or scheduled 1:1 activities had been provided for Resident #8. He indicated he doubted she had even been invited to the Birthday party. There was no reason given as to why the activity care plan had not been revised if the intervention was not effective. 2. The clinical record for Resident #213 was reviewed on 11/12/14 at 9:48 A.M. Resident #213 was admitted to the facility, on 10/10/11 and readmitted to the facility on 12/13/13, with diagnosis, including but not limited to dementia, spinal stenosis, atrial fibrillation, hypertension, osteoporosis, hearing loss, glaucoma, and pseudobulbar affect. The most recent MDS (Minimum Data Set) assessment quarterly review, completed on 08/28/14, indicated the resident was severally cognitively impaired, nonambulatory, and required extensive staff assistance for transfers and wheelchair locomotion.			

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	An activity assessment, completed on 12/26/13, indicated classical and older songs were very important to the resident, keeping up with the news and Bible were very important, going outside for fresh air was very important, and participating in religious activities were very important to the resident. In addition, the resident was assessed to have moderate to severe cognitive impairments. An activity interests survey, completed on 12/16/13, indicated the resident was a first grade teacher and then a homemaker, volunteered at church and played the piano, liked cats and dogs, had a past interest in sewing, attended baseball games with her father, previously enjoyed walks and card games, had a previous interest in growing and arranging flowers, enjoyed baking, cooking, and canning in the past, and used to lead singing. Her current interests were looking at photo albums, magazines, being with groups, friends, and also being alone, and would watch a little television, especially game shows and news. The care plans regarding activities, current through 12/04/14, included the following plans: Problem - "Resident exhibits severe cognitive impairments...Goal Resident will off [sic]			

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	eye contact and verbal response during 1:1 visits through next review... Problem - "LTC [Long term Care] - My cognitive loss has increased, which has affected my willingness to attend group activities and visit with my husband/staff/others. Goal Goals through next review; I will receive the help I need regarding my daily activities Approach provide encouragement towards activities available and reminders." An activity quarterly progress note, completed on 08/29/14 at 3:21 P.M., indicated there had been no significant changes from the prior assessment in the resident's activity levels. The assessment indicated the resident was able to determine her own level of activity with cues. The assessment indicated the resident did not attend a lot of activity, would sit in the lounge with her husband, and had participated in one art class, church, country ride, music programming, pet therapy visits, sensory stimulation programs, sing a longs, social time on the unit and had visitors. The assessment indicated 1:1 support and encouragement visits were to continue. Resident #213 was observed, on 11/10/2014 at 2:33 P.M., in a recliner with the leg rest elevated, in a darkened			

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	lounge area on her hall. The resident was awake. The television was not turned on. Resident #213 was observed, on 11/12/2014 at 9:23 A.M., in the assisted dining room, sitting at the table staring out the window. She spoke nonsensically when asked about her breakfast. Resident #213 was observed, on 11/12/2014 at 9:37 A.M., still in the assisted dining room being fed by Employee #32. Activity staff were noted pushing other residents from the unit to the location of the activities scheduled for the morning. Resident #213 was observed, on 11/12/14 at 10:00 A.M., being pushed from the assisted dining room to the small lounge on her hall. She was placed still seated in her wheelchair facing the television. The television was playing a "Queen Latifah" talk show. The resident looked at the television some and then also looked around the room and hallway. Resident #213 was observed, on 11/12/2014 at 10:16 A.M., seated in her wheelchair in the small lounge/cubby area on her hall. She was awake and facing the television. Resident #213 was observed, on			

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	11/12/2014 10:49 A.M., still seated in her wheelchair in the small lounge/cubby area on her hall. She was noted to be intermittently dozing and then would awake. Staff were noted walking by but there were no staff directly observing and/or interacting with Resident #213. A Basic Nursing Aide (BNA) was observed, on 11/12/2014 at 11:04 A.M., to approach the resident and offered her a magazine. The resident became slightly belligerent and refused the magazine. The BNA then directed and assisted the resident to put her feet on the foot pedal. The resident repeatedly asked to "go home." The BNA then handed her a flashcard and left the area. The resident studied the flashcard for a few minutes. At 11:05 P.M., a housekeeper emptied a trash can in the lounge where the resident had been seated and the resident tried to tell the housekeeper she did not want the flash card. The housekeeper did not acknowledge the resident. At 11:06 A.M., a nurse pushed the resident to her room to use the restroom. Resident #213 was observed, on 11/12/2014 at 1:49 P.M., seated in a recliner on the unit lounge/cubby area. A Christmas music program was playing on the television but the resident was trying to get the attention of people walking in			

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	the hallway. She was noted to have the foot rest down but not locked in the down position. She was also fiddling with a blanket on her lap. Resident #213 was observed, on 11/12/2014 at 2:20 P.M., still seated in the recliner in the hall lounge. Resident #213 was observed, on 11/13/2014 at 9:44 A.M., in the assisted dining room being fed and cued to eat. Resident #213 was observed, on 11/13/2014 at 10:08 A.M., still in the assisted dining room feeding herself. Staff were in the room but were not feeding or assisting her. Resident #213 was observed, on 11/13/2014 at 10:19 A.M., pushed from the assisted dining room to the television/cubby lounge on the hallway and left in her wheelchair between a small couch and a recliner. There were no staff in the area who were directly observing the resident The television was on a Make a Deal game show. On 11/13/2014 at 11:15 A.M., CNA #31 was observed giving Resident #213 a teddy bear to hold. The resident was smiling, accepted the bear, and held it posing with it for a few minutes. CNA			

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	#31 indicated the resident did not go to many activities, loved to watch TV, and the resident's husband visited in the evenings and did activities with her. On 11/13/2014 at 11:41 A.M., Resident #213 was observed in the hallway by the medication cart without staff around in her wheelchair. The foot pedals to the wheelchair were in place. The activity schedule for 11/10/14 was as follows: 9:30 A.M. - Exercises in the Meeting House 10:00 A.M. - Resident Council in the Meeting House 2:00 P.M. - Bingo in the Meeting House The Activity schedule for 11/12/14 was as follows: 9:30 A.M. Sing with Sue in the South unit dining room 10:30 A.M. Exercises in the South Unit dining room 2:00 P.M. - Country Ride 6:00 P.M.- Massage North dining room/EW The Activity schedule for 11/13/14 was as follows: 9:30 A.M. Exercises South dining room 10:00 A.M. Bible Study - South dining room			

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	2:00 P.M. - Birthday party - Meeting house 6:30 P.M. - 1st Baptist Church - Meeting house The Activity Participation logs for Resident #213, from 11/07/14 - 11/13/14, indicated the resident had attended two music activities on 11/07/14. She was unavailable for the exercises and resident council activities held on 11/10/14. She attended two 1:1 which each only lasted 5 minutes on 11/11/14 and 11/12/14. During an interview on 11/14/14 at 10:45 A.M., the Activity Director indicated the daily 1:1's documented on 11/11/14 and 11/12/14 were not scheduled 1:1's but were brief greetings by activity staff during the course of the day. He indicated the resident had not really been involved lately in activities but her family did some activities with her when they visited. There was no reason given as to why the scheduled 1:1 activities care planned had not occurred and Resident #213 had not been invited or assisted to other scheduled activities. The Activity Director indicated other than some musical programs in the evenings, there were not many activities held on the unit where Resident #213 resided. He did not offer any type of activity nursing staff could provide for Resident #213 while			

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	she was seated in the recliner in the lounge on her nursing unit. 3.1-33(a)			
F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by			

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	the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on record review and interviews, the facility failed to comprehensively assessed a decline in bladder function for 2 of 2 residents reviewed for bladder continency. (Resident #210 and Resident #238) Findings include: On 11-12-14 at 11:53 A.M., a review of the clinical record for Resident #210 was conducted. The record indicated the resident was admitted on 6-20-14. The resident's diagnoses included, but were not limited to: memory loss, osteoporosis, and hyperlipidemia. The form titled "Three-day Bowel & Bladder Diary" dated 6/20, 6/21, and 6/22/2014, indicated Resident #210 had no incontinent episodes. The Admission Minimum Data Set (MDS) assessment for Resident #210, completed on 7-1-14, indicated the resident was always continent of her bladder and her BIM's (Brief Interview Mental Status) score was 3 (a score of 0-7=severe cognitive impairment) A Quarterly MDS assessment, completed on 9-18-14, indicated the resident had	F000272	**F 272** Restorative toileting programs for resident #210 and 238 were reviewed. No changes were made. Staff is to make sure residents are prompted to use the toilet per their respective care plans. All other residents on restorative toileting programs were audited to assure their toileting needs are care planned and met. The procedure on Restorative Nursing Program policy has been revised. (Attachment E) Nursing staff shall document the voidings of those residents who are on Restorative Toileting Programs. Also included in the revised procedure is the process to identify residents who might benefit from a restorative toileting program. At the time of admission and when change in continence pattern, a 3 day bladder diary will be completed and a Bowel and Bladder assessment will be completed. This shall be done before developing a restorative toileting program. Individualized interventions for each resident will be communicated to nursing staff via the Comprehensive Care Plan. Nursing staff were in-serviced on the revised procedure (Attachment E) to prompt residents to use the toilet on their	12/10/2014

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	declined in her bladder function and was occasionally incontinent (less than 7 episodes of incontinence) and was on a toileting program. The resident's BIMS score remained a 3. Resident #210's careplan's, dated 7/2/14, indicated the following: ...2. Restorative Urinary Toileting-Resident was unable to find her restroom without staff cues and resident forgets to tell staff when she has a bowel movement. Interventions included but were not limited to: "...staff to anticipate and offer toileting when I awaken for the day, after breakfast, before activities and lunch and supper, and after activities and lunch and supper at bedtime...." The form titled "Restorative Toileting Resident Detail Form 11//7/14 Thru 11/13/14," received from the Restorative Nurse, indicated the form documented entrees to when the resident was toileted each day. The information provided did not include the time of day the resident was toileted and included all shifts. 11/7/14 Continent/toileted 3 times 11/8/14 Continent/toileted 3 times, Incontinent/toileted 1 time 11/9/14 Continent/toileted 2 times 11/10/14 Continent/toileted 1 time, Incontinent/toileted 1 time, and Refused 1 time		assigned times and document the outcome. NTL or designee will monitor charts on admission and those with a change in continence pattern charts to make sure Bladder Assessments are complete. This will be on-going and reported to the DON or designee via the Healthcare Community Reports (Attachment G) daily. The DON or designee will submit the summary of findings to the QAPI committee quarterly for review and recommendation. Alleged date of compliance 12/10/2014.	

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	11/11/14 Continent/toileted 3 times, 11/12/14 Continent/toileted 1 time, Refused, 2 times On 11-13-14 at 3:00 P.M., the form titled "Restorative Toileting Resident Detail" for Resident #210 was reviewed with the Restorative Nurse. She explained the form did not indicate the time the resident was continent or incontinent to assess incontinent patterns. She indicated according to each resident's restorative plan there should at least be a minimal of 6 entrees a day, one upon rising, before and after meals, before and after activities, and before bed. Another form titled "ADL [Activity of Daily Living] Supplement Part 1: ADL Problem Evaluation was reviewed with the Restorative Nurse and indicated the "physical reason why help was needed" box was checked as follows "...mental errors: incomplete performance-begins toileting sequence, but cannot complete task without staff intervention...." The Restorative Nurse indicated the ADL Problem Evaluation was her assessment tool used to place a resident on the Restorative Urinary Toileting Plan. On 11-14-14 at 2:15 P.M., the Restorative Nurse provided a Nursing Admission Assessment dated 6-20-14. The assessment indicated the resident			

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	was continent of bladder and wore a brief. 2. On 11-12-14 at 10:17 A.M., a review of the clinical record for Resident #238 was conducted. The record indicated the resident was admitted on 7-7-14. The resident's diagnoses included but were not limited to: chronic kidney disease, depressive disorder, hypertension, history of urinary tract infections, dementia, dyspnea and respiratory abnormalities. The form titled "Three-day Bowel & Bladder Diary," dated 7/7, 7/8 and 7/9/2014, indicated the resident had one incontinent episode on 7-8-14 at 8:30 A.M. The Admission Minimum Data Set (MDS) Assessment dated 7-16-14, indicated the resident was not on a toileting program and was occasionally incontinent. The resident's BIMS score was 3, severe cognitive impairment. A Quarterly MDS Assessment, dated 10-9-14, indicated the resident had declined and was currently on a trial toileting program and was now frequently incontinent. The resident's BIMS score was 1, severe cognitive impairment.			

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	Resident 238's careplan's, dated 10/31/14, indicated the following: ...3. Restorative Urinary Prompted Toileting-resident was incontinent of bladder and had the ability to be more continent with prompted bladder program. Goal- resident to have fewer incontinent episodes. The intervention included but were not limited to: "... prompt me to void by giving me reminders every 2-3-hours. Staff anticipate and offer toileting upon rising in the am, after breakfast, before and after lunch and supper and at bedtime and prn [as needed]...." During an interview on 11-13-14 at 2:03 P.M., CNA #16 and CNA #15 indicated the Resident #238 had not be taken to the restroom after lunch. CNA#16 further indicated the resident "usually finds the restroom on her own" and takes herself to the restroom. When asked about the Restorative Program for toileting a resident, the CNA's used their iPad (hand-held computer) and indicated the information was located in their iPad. When they reviewed the information about the restorative toileting program there was no directions as to when the resident was to be toileted. CNA #16 looked at the careplan section on their			

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	iPad and was able to review the restorative toileting plan for the resident. Both CNA's were unaware of the resident's need to be toileted before and after meals, and before and after activities to optimize bladder function. On 11-13-14 at 2:50 P.M., a review of the form titled "Restorative Toileting Resident Detail Form 11/7/14 Thru 11/13/14" indicated the following; 11/7/14 Continent/toileted 2 times, Incontinent/toileted 11/8/14 Continent/toileted 1 time, Incontinent/toileted 2 times 11/9/14 Continent/toileted 1 time, Incontinent/toileted 2 times 11/10/14 Continent/toileted 2 times, Incontinent/toileted 1 time 11/11/14 Continent/toileted 2 times, Incontinent/toileted 1 time 11/12/14 Continent/toileted 2 times, Incontinent/toileted 1 time 11/13/14 Incontinent/toileted 1 time During an interview on 11-13-14 at 3:00 P.M., the Restorative Nurse indicated she initiated the Restorative Urinary Toileting program for Resident #210 and #238 using an ADL (Activities of Daily Living) Problem Evaluation form. She explained the CNA's filled out the section titled "What the Resident Can Do" and she fills out the section titled "Why Physical Help Was Needed." The			

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	Restorative Nurse further indicated the 3 day bladder assessments were completed on each resident on admission but had not been repeated prior to placing the residents on the Restorative Program for incontinence. The Restorative Nurse indicated once the plan is "set up" she expects the nurse manager/team leader/CNA's to follow the plan of care. A review of a form titled "Restorative Toileting Resident Detail" for Resident #238 was received from the Restorative Nurse. She explained the form did not indicate the time the resident was continent or incontinent to fully assess incontinent patterns. She agreed according to each resident's restorative bladder plan, there should at least be a minimal of 6 entrees a day. The facility's assessment form did not assess any current signs or symptoms of urinary tract infection, did not include an evaluation of potential diagnosis and/or medications. On 11-13-14 at 3:20 P.M., the Administrator provided a policy titled "Bowel and Bladder Program" revised 11/14. The policy indicated "...Incontinent residents are identified, assessed and provided appropriate treatment to maintain as much normal urinary function as possible...." On 11-13-14 at 3:40 P.M., a form titled			

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	"ADL Supplement Part 1: ADL Problem Evaluation was reviewed with the Restorative Nurse and indicated the physical reason why help was needed box was checked as follows "...Anxiety limitations - symptoms of anxiety limit functioning for toileting task...."The Restorative Nurse indicated this assessment tool placed the resident on the Restorative Urinary Toileting Plan. On 11-13-14 at 4:00 P.M., the Restorative Nurse provided the current policy titled" Restorative Nursing Program". The policy indicated "...4. The nursing staff may determine that a restorative program is needed, such as bladder retraining, that does not require the intervention of skilled therapies, and may assess and implement an RNP [Restorative Nursing Program] as needed. 5. Once an RNP has been established, the appropriate staff are trained in carrying out the programs and shall sign a training form as proof of such training. 6. RNA's [Restorative Nurse Assistant] shall document daily the minutes of each restorative program being carried out and shall note any exceptions to the normal program (i.e. why treatment was withheld, if patient refused treatment.) Any unusual complaints from the patient regarding the program are to be			

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	noted and communicated to the nursing staff (if involved in developing the plan.)...." On 11-14-14 at 2:00 P.M., an interview was conducted with the Administrator, the Director of Nursing, the Restorative Nurse and the MDS nurse. The Restorative Nurse indicated the assessment for a restorative program starts with the CNA's filling out the section "What the Resident Can Do" then the Restorative Nurse assessed the resident to find out the reason and why the physical help is needed. The Restorative Nurse further indicated she placed a check in a box indicating the resident had certain "mental errors" or "physical limitations". The group had no answer as to when or how a resident's incontinent episodes were assessed and if the program was assisting the residents bladder function. The group were asked if they had any other documentation for Resident #210 or #238 to indicate a full bladder assessment was completed prior to placing the resident on the restorative plan. No new information was given. 3.1-31(a)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interviews, the facility failed to ensure a careplan was developed for 1 of 5 residents reviewed for unnecessary medications. (Resident #104)	F000279	**F 279 Develop Comprehensive Care Plans** Resident #104 had a care plan for the usage of Lasix	12/10/2014

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	Findings include: On 11-12-14 at 10:57 A.M., a review of the clinical record for Resident # 104 was conducted. The record indicated the resident was admitted on 12-12-2012. The resident's diagnoses included, but were not limited to: hypertension, joint pain, depressive disorder, anxiety state, edema, and abnormal gait. The Medication Administration Record (MAR) indicated the resident was on Lasix (a diuretic) 40 milligrams to be taken daily for edema. In addition, the resident's Treatment Administration Record (TAR) indicated the resident was to wear TED hose (compression stocking to decrease edema) daily and elevate her feet 2 hours every morning. The Annual Minimum Data Set (MDS) Assessment, dated 6-5-14, and the Quarterly MDS Assessment, dated 8-21-14, indicated the resident was taking a diuretic daily. Resident 104's careplan indicated there was no plan to address the resident's edema and use of a diuretic. The nutritional careplan, dated 9-5-14, did not mention the use of a diuretic and potential water weight loss.		under "urinary incontinence," generated on 7/22/2014. This care plan was reviewed and revised on 11/28/2014 for the use of Lasix. Care plans for residents with edema were audited by MDS nurses to make sure their care plans were up to date. This information was communicated with licensed nurses. Licensed nursing staff were in-serviced and re-educated on documentation and updating care plans (Attachment H). The Nurse Team Leader (NTL) or designee will review the 24 hour report sheet daily for new residents with edema. They will audit charts to make sure interventions are in place and that the care plan has been updated. The NTL or nurse on call will report findings to the Director of Nursing (DON) or designee via the Healthcare Community Reports (Attachment G) daily. The DON or designee will	

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	On 11-14-14 at 11:28 A.M., Resident #104 was observed in her room with her feet up and her TED hose on. Her feet and ankles appeared to be swollen. During an interview, on 11-14-14 at 11:31 A.M., RN #10 indicated Resident #104 was currently taking Lasix for edema. RN #10 further indicated she could not locate a careplan for the use of a diuretic for Resident #104 nor a careplan for resident's problem with edema in her lower extremities. During an interview, on 11-14-14 at 11:38 A.M., the Assistant Director of Nursing indicated she was unable to locate a careplan for the use of a diuretic and/or for lower extremity edema. 3.1-35(a)		submit the findings to the QAPI committee quarterly for review and recommendations. Alleged date of compliance 12/10/2014.	
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to ensure	F000282	**F 282 Services by qualified Persons**	12/10/2014

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	that the care plan regarding fall prevention was followed for 1 of 3 residents reviewed for falls. (Resident #213) Finding includes: The clinical record for Resident #213 was reviewed on 11/10/14 at 2:49 P.M. Resident #213 was admitted to the facility on 12/13/13, with diagnosis, including but not limited to dementia, spinal stenosis, atrial fibrillation, hypertension, osteoporosis, hearing loss, glaucoma, and pseudobulbar affect. The most recent MDS (Minimum Data Set) assessment quarterly review, completed on 08/28/14 indicated the resident was severely cognitively impaired, nonambulatory, and required extensive staff assistance for transfers for wheelchair locomotion. The Nursing Notes, from 07/27/14 - 11/13/14, indicated Resident #213 had fallen six times. A fall risk assessment, completed on 09/04/14 at 2:42 P.M., indicated the resident was at risk for falls due to intermittent confusion, three or more falls in the past three months, chair bound and required assistance with elimination,		Resident #213 has not fallen since 11/10/2014. Care plans were reviewed and all interventions are being followed as to prevent falls. All other residents who are at risk of falling had their care plans reviewed and revised as needed to prevent falls. New interventions implemented after a fall will be communicated to the nursing staff via the 24 hour report book. Nursing staff were in-serviced and re-educated to follow all interventions to prevent resident falls (Attachment I.) The Assistant Director of Nursing (ADON) or designee will continue to audit charts for new interventions after each fall incomplete documentation will be corrected immediately and communicated with nursing staff via the 24 hour report book. This will be ongoing. Findings will be submitted to the DON weekly. The DON or designee will submit a summary of	

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	balance problems while standing, required assertive devices, and had predisposing diseases. The care plan related to fall prevention, initiated on 01/02/14 and current through 12/04/14, indicated the resident had a potential for falls related to weakness, unsteadiness, lethargy at times, daily use of diuretic, and drugs for Alzheimer's and dementia. The goal was for the resident to have no falls/injury until the next assessment. The interventions were: have resident use walker when she want to walk. Provide limited to extensive assistance of one or two with ambulation. Provide more assistance if signs of, provide extensive assist of 1-2 transfers. Use stand aid and extensive assist of 2 when resident is unable to stand well for transfers, keep pathway in room to bathroom clear and floors free from spills and clutter, provide adequate glare free lighting, ensure that resident uses her glasses's daily when awake, keep call light and personal items within reach. Remind resident to use call light as needled, as she is forgetful and does not use it much, Ensure that resident uses non-skid footwear for transfers and ambulation, check on resident at frequent intervals regarding her needs/safety, as she does not use call light on her own, check vital signs weekly and prn and		findings to QAPI committee quarterly for review and recommendations. Alleged date of compliance 12/10/2014.	

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	monitor BP(blood pressure) for hypotension d/t (due to) use of diuretic, HCTZ (hydrochlorothiazide). Report significant readings to MD (Medical Doctor), Observe for side effects related to use of Exelon (an antidepressant) such as dizziness, fatigue, somnolence, confusion and report if noted, ensure that floor around resident is free of objects she may try to pick up, go green program to prevent falls, be vigilant if resident appears restless, and take her for a walk or wheelchair rides at those times, close observation and report on increased activity and behavior changes while on Nudexta (a mood stabilizing drug), observe for signs of pain every shift and give resident pain med when signs of pain are noted. Monitor effectiveness, do not leave in w/c next to the recliner where she usually sits. The Nursing Notes, dated 07/27/14 at 1:08 P.M. indicated the resident was found face down on the floor just inside Room 502. She had been left unobserved for a few minutes. The resident suffered a laceration above her right eye and a small scrape above her left ear. A post fall assessment, completed on 07/27/14 at 1:08 P.M., indicated the resident was wearing shoes at the time of her fall, had apparently gotten herself up			

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	out of her wheelchair and ambulated unassisted from outside room 504 to room 502. The action plan indicated "Difficult to determine; showed no indication of restlessness just a few minutes prior." The Nursing notes, dated 08/15/14 at 6:31 P.M., indicated the resident was found on the floor in the back lounge. A post fall investigation assessment, completed on 08/15/14 at 10:45 P.M. indicated the resident was wearing shoes at the time of her fall. Had been attempting to transfer herself in the East hallway lounge. The summary factor indicated the resident had been "quite active and talkative" and was "known to suddenly get up to walk without." (sic) The action plan was to "continue close observations." A Nursing Note, dated 09/13/14 at 7:32 P.M., indicated the resident was found on the floor by a couch near the dining room at 6:55 P.M. A post fall investigation assessment, completed on 09/13/14 at 11:42 P.M., indicated the resident fell while transporting herself in the lounge by the dining room. The resident was wearing shoes at the time of the fall. There was			

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	no action plan put into place after the fall. The Nursing Notes, dated 10/01/14 at 10:06 P.M., indicated the nurse was alerted that the resident was on the floor. The resident was found seated on the floor in front of a recliner. The fall was not witnessed and there were no signs of injury. The post fall investigation assessment, completed on 10/01/14 at 10:32 P.M., indicated the resident was at a high risk for falls, had a history of falls, and had been checked on 5 minutes prior to her fall. The resident was documented as wearing shoes at the time of the fall, and was assumed to have been attempting to transfer herself from the wheelchair to the recliner in the day room or activity room. The resident had just returned from an outing and was left unattended in her wheelchair near the recliner where she usually sat. The action plan was to ask staff not to leave resident near the recliner while she was in her wheelchair. Nursing notes, dated 11/01/14 at 10:28 P.M. indicated the resident was found laying on the floor on her left side and holding her head up. The resident's wheelchair was behind her. She had attempted to transfer herself from the wheelchair into the recliner.			

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	A post fall investigation, completed on 11/01/14 at 10:36 P.M., indicated the resident was at a high risk for falls, had a history of falls, and had been checked on 20 minutes prior to her fall. The resident was documented as having shoes on at the time of the fall, and had been attempting to get up from a chair, while in the television lounge. There was no call light documented as having been in reach. The assessment indicated the resident was left in her wheelchair near a recliner and she tried to transfer herself. The action plan for the staff to make sure resident was transferred to the recliner after supper and not left in her wheelchair alone. A Nursing Note, dated 11/10/14 at 10:35 P.M., indicated the resident was found seated on the floor in her room. She had an abrasion with edema and a light blue discoloration noted just below her left knee. There was also a light blue discoloration noted just above her coccyx and stool in her brief. A post fall investigation, completed on 11/10/14, indicated the resident was a high risk for falls prior to her fall, had a history of falls, and had been checked on 15 minutes prior to her fall. The resident was attempting to go to the bathroom and			

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	was wearing socks when she fell. The resident's bed rails were elevated and her call light was within reach. The interventions was to continue frequent monitoring and to toilet the resident prior to her going to bed. Resident #213 was observed, on 11/12/14 at 10:00 A.M., being pushed from the assisted dining room to the small lounge on her hall. She was placed, still seated in her wheelchair, facing the television. beside a recliner. The resident was awake and looked around. At 10:16 A.M., Resident #213 remained seated in her wheelchair in the small lounge/cubby area on her hall. She was awake and facing the television. Resident #213 was observed on 11/12/2014 10:49 A.M., still seated in her wheelchair in the small lounge/cubby area on her hall. She was noted to be intermittently dozing and then would wake. Staff were noted walking by but there was no staff directly observing Resident #213. Resident #213 was observed, on 11/13/2014 at 10:19 A.M., pushed from the assisted dining room to the television/cubby lounge on the hallway and left in her wheelchair between a small couch and a recliner. There were			

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	no staff in the area who were directly observing the resident The resident's feet were on the foot pedals and she was noted to rock her wheelchair a few times and tried to move the foot pedals. She did get her right foot off of the foot pedal of the wheelchair. On 11/13/2014 at 10:23 A.M., a nurse came out to a medication cart in the cubby area next to the television lounge, Resident #213 was noted to propel her wheelchair backwards into the hallway with her right foot, turned her wheelchair a little by rocking and using her right foot. At 11/13/2014 at 10:25 A.M., a visitor moved the resident back towards the television cubby/lounge so he could push another resident past her. On 11/13/2014 at 11:41 A.M., Resident #213 was observed in the hallway by the medication cart without staff around in her wheelchair. The foot pedals to the wheelchair were in place. During an interview, conducted on 11/13/2014 at 11:15 A.M., CNA #31 indicated the resident was a fall risk and was to be gotten out of bed as soon as she awakened, was not to be left alone in the bathroom, was safe to be in her wheelchair as long as the foot pedals were in place, otherwise she was to be			

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	put in the recliner with the footrest elevated. During an interview on 11/13/14 at 10:43 A.M., the Unit Clerk, Employee #32, indicated there was a assignment sheet the CNA's could utilize, which was kept on the specific hallways. Review of the form for Resident #213 indicated the resident was not noted to be a fall risk and there were no comments regarding specific fall precautions for the resident. 3.1-35(g)(2)			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observations, record review and interviews, the facility failed to ensure 2 of 3 residents reviewed for a decline in	F000315	**F 315** Restorative Urinary Toileting Plans for #210 and 238 have been reviewed and care plan links have	12/10/2014

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	bladder function received a thorough assessment and individualized interventions to improve and/or manage urinary incontinence. (Resident #210 and Resident #238) Findings include: 1. On 11-12-14 from 9:15 A.M. thru 10:54 A.M., Resident #210 was observed lying in her bed. At 10:55 A.M., the resident was observed walking from her room using a walker. At 11:00 A.M., the resident walked into the TV room and sat in a chair. The resident remained in the chair until 11:45 A.M. The resident was observed getting out of the chair by herself and walked into the hallway. RN #17 was observed grabbing the resident's walker and taking it to her. RN #17 asked the resident if she was ready for lunch. RN #17 was observed taking the resident to the dining room at 11:51 A.M. The resident was not observed to be toileted during this time. On 11-12-14 at 1:10 P.M., Resident #210 was observed in the TV room sitting in a chair. At 1:15 P.M., the resident walked with a walker escorted by CNA #18 to the restroom. CNA #18 indicated she had not taken the resident to the		been made so that the CNAs will know the current interventions for toileting programs to help maintain and restore as much normal bladder function as possible. All toileting plans of residents who are on Restorative Urinary Toileting programs have been reviewed and interventions linked so that the CNAs can view the interventions for toileting programs to help maintain and restore as much normal bladder function as possible. Nursing staff have been in-serviced re-educated on how to access the individual resident's toileting care plans and the importance of following through with the interventions (Attachment F). Nursing staff shall document voidings of those residents who are on Restorative Toileting Programs. Also included in the revised procedure is the process to identify residents who might benefit from a restorative toileting program. At the time of admission and a change in continence pattern, a 3 day bladder diary will be completed and a Bowel and Bladder assessment will be completed. This shall be done before developing a restorative toileting program. Individualized interventions for each resident will be communicated to nursing staff via the Comprehensive Care Plan. Nursing staff were in-serviced on the revised procedure (Attachment F) to prompt	

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	restroom after lunch. On 11-12-14 at 11:53 A.M., a review of the clinical record for Resident #210 was conducted. The record indicated the resident was admitted on 6-20-14. The resident's diagnoses included, but were not limited to: memory loss, osteoporosis, and hyperlipidemia. Resident #210's careplan's, dated 7/2/14, indicated the following: ...2. Restorative Urinary Toileting-Resident was unable to find her restroom without staff cues and resident forgets to tell staff when she has a bowel movement. Interventions included but were not limited to: "...staff to anticipate and offer toileting when I awaken for the day, after breakfast, before activities and lunch and supper, and after activities and lunch and supper at bedtime...." The form titled "Three-day Bowel & Bladder Diary" dated 6/20, 6/21, and 6/22/2014, indicated the Resident #210 had no incontinent episodes. The admission Minimum Data Set (MDS) Assessment for Resident #210, completed on 7-1-14, indicated the resident was always continent of her bladder and her BIMS' (Brief Interview Mental Status) score was 3 (a score of		residents to use the toilet on their assigned times and document the outcome. NTL or designee will monitor charts on admission and a change of continence pattern charts to make sure Bladder Assessments are complete. This will be on-going and reported to the DON or designee via the Healthcare Community Report (Attachment G) daily. The DON or designee will submit the summary of findings to the QAPI committee quarterly for review and recommendation. Alleged Date of Compliance 12/10/2014.	

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	0-7=severe cognitive impairment). A Quarterly MDS assessment, completed on 9-18-14, indicated the resident had declined in her bladder function and was occasionally incontinent (less than 7 episodes of incontinence) and was on a toileting program. The resident's BIMS score remained a 3. On 11-13-14 at 10:15 A.M., a review of the form titled "Restorative Toileting Resident Detail Form 11//7/14 Thru 11/13/14" received from the Restorative Nurse indicated the documented entrees by the staff regarding the residents toileting. The information provided did not include the time of day the resident was toileted and included all shifts. 11/7/14 Continent/toileted 3 times 11/8/14 Continent/toileted 3 times, Incontinent/toileted 1 time 11/9/14 Continent/toileted 2 times 11/10/14 Continent/toileted 1 time, Incontinent/toileted 1 time, and Refused 1 time 11/11/14 Continent/toileted 3 times, 11/12/14 Continent/toileted 1 time, Refused, 2 times The form titled "Restorative Toileting Resident Detail" for Resident #210 was with reviewed with the Restorative Director. She explained the form did not indicate the time the resident was			

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	continent or incontinent to assess incontinent patterns. She agreed according to each resident's restorative plan there should have been at least be a minimal of 6 entrees a day, one upon rising, before and after meals, before and after activities, and before bed. On 11-14-14 at 2:15 P.M., the Restorative Nurse provided a Nursing Admission assessment, dated 6-20-14. The assessment indicated the resident was continent of her bladder and wore a brief. 2. On 11-12-14 at 10:17 A.M., a review of the clinical record for Resident #238 was conducted. The record indicated the resident was admitted on 7-7-14. The resident's diagnoses included but were not limited to: chronic kidney disease, depressive disorder, hypertension, history of urinary tract infections, dementia, dyspnea, and respiratory abnormalities. The form titled "Three-day Bowel & Bladder Diary" dated 7/7, 7/8, and 7/9/2014, indicated the resident had one incontinent episode on 7-8-14 at 8:30 A.M. The Admission Minimum Data Set (MDS) assessment, dated 7-16-14,			

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	indicated the resident was not on a toileting program and was occasionally incontinent. The resident's BIMS score was 3. A Quarterly MDS assessment, dated 10-9-14, indicated the resident was currently on a trial toileting program and was frequently incontinent. The resident's BIMS score was 1. Resident #238's careplan's, dated 10/31/14, indicated the following: 1. Potential for decline in self performance with ADL's related to confusion/dementia. The interventions were: to provide set up and limited assist with ambulation to and from the restroom. 2. Resident was at risk for increased bowel and bladder incontinence related to confusion from dementia. The interventions included but were not limited to: staff to anticipate and meet all needs every shift and offer toileting per plan. See separate restorative urinary prompted toileting care plan, provide pull ups adult incontinent products and monitor incontinence every 2 hours, offer to assist to the bathroom whenever observed to be awake at night. 3. Restorative Urinary Prompted Toileting-resident was incontinent of bladder and had the ability to be more continent with prompted			

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	bladder program. Goal- resident to have fewer incontinent episodes. The interventions included, but were not limited to: "... prompt me to void by giving me reminders every 2-3-hours. Staff anticipate and offer toileting upon rising in the am, after breakfast, before and after lunch and supper and at bedtime and prn [as needed]...." On 11-13-14 at 9:24 A.M., Resident #238 was observed lying in her bed with her eyes closed. On 11-13-14 at 9:45 A.M., Resident #238 awoke and CNA #15 was observed assisting the resident to the restroom and the resident's pull up (adult diaper) was changed. CNA #15 then assisted with dressing the resident. The resident was walked to hallway table and her breakfast was served to her. The resident was observed sitting at the table until 11:29 A.M. At that time, the resident was escorted to the dining room by CNA #15 along with 2 other residents. CNA #15 seated each resident at a table and returned to the unit. On 11-13-14 at 12:55 P.M., the resident was observed sitting in the hallway across from a birdcage, she was watching everyone come and go down the hallway.			

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	At 1:35 P.M., the resident was observed walking the units, the resident went thru North Unit, then thru the Rehab Unit, and ended up on the Gables Unit. She was observed going up to each exit door and trying to open it. She walked off the Gables Unit at 1:43 P.M. The resident walked back thru the Rehab Unit and started on the North Unit when another resident asked her if she was going the the birthday party. A staff member encouraged the resident to attend the activity. The resident walked to the activity and a staff member assisted the resident into a seat at 1:52 P.M. The resident was not observed to be toileted after lunch and before an activity. During an interview, on 11-13-14 at 2:03 P.M., CNA #16 and CNA #15 indicated the resident had not been taken to the restroom after lunch. CNA #16 further indicated the resident "usually finds the restroom on her own" and takes herself to the restroom. When asked about the Restorative Program for toileting, the CNA's used their iPad (hand-held computer) and indicated the information was located in their iPad. When they reviewed the information about the restorative toileting program there was no directions as to when the resident was to be toileted. CNA #16 looked at the careplan section on their iPad and was			

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	able to review the restorative toileting plan for the resident. Both CNA's were unaware of the resident's need to be toileted before and after meals, and before and after activities to optimize bladder function. On 11-13-14 at 2:50 P.M., a review of the form titled "Restorative Toileting Resident Detail Form 11/7/14 Thru 11/13/14" indicated the following; 11/7/14 Continent/toileted 2 times, Incontinent/toileted 11/8/14 Continent/toileted 1 time, Incontinent/toileted 2 times 11/9/14 Continent/toileted 1 time, Incontinent/toileted 2 times 11/10/14 Continent/toileted 2 times, Incontinent/toileted 1 time 11/11/14 Continent/toileted 2 times, Incontinent/toileted 1 time 11/12/14 Continent/toileted 2 times, Incontinent/toileted 1 time 11/13/14 Incontinent/toileted 1 time During an interview on 11-13-14 at 3:00 P.M., the Restorative Nurse indicated she initiated the Restorative Urinary Toileting program for Resident #210 and #238 using an ADL (Activities of Daily Living) Problem Evaluation form the facility presently utilized. She explained the CNA's fill out the section titled "What the Resident Can Do" and she filled out the section titled "Why Physical			

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	Help Was Needed". The Restorative Nurse further indicated the 3 day bladder assessments were completed on each resident at admission but had not been repeated prior to placing the residents on the Restorative Program for incontinence. The Restorative Nurse indicated once the plan is "set up" she expects the nurse manager/team leader/CNA's to follow the plan of care. She further indicated both residents wore a pull up. A review of a form titled "Restorative Toileting Resident Detail" for Resident #238 was receive from the Restorative Nurse. She explained the form did not indicate the time the resident was continent or incontinent to fully assess incontinent patterns. She agreed according to each resident's restorative bladder plan, there should at least be a minimal of 6 entrees a day. The facility's assessment form did not assess any current signs or symptoms of a urinary tract infection, did not include an evaluation of potential diagnosis and or medications which could adversely affect bladder continency. On 11-13-14 at 3:20 P.M., the Administrator provided a policy titled "Bowel and Bladder Program" revised 11/14. The policy indicated "...Incontinent residents are identified, assessed and provided appropriate			

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	treatment to maintain as much normal urinary function as possible...." On 11-13-14 at 4:00 P.M., the Restorative Nurse provided the current policy titled" Restorative Nursing Program". The policy indicated "...4. The nursing staff may determine that a restorative program is needed, such as bladder retraining, that does not require the intervention of skilled therapies, and may assess and implement an RNP [Restorative Nursing Program] as needed. 5. Once an RNP has been established, the appropriate staff are trained in carrying out the programs and shall sign a training form as proof of such training. 6. RNA's [Restorative Nursing Assistant] shall document daily the minutes of each restorative program being carried out and shall note any exceptions to the normal program (i.e. why treatment was withheld, if patient refused treatment.) Any unusual complaints from the patient regarding the program are to be noted and communicated to the nursing staff (if involved in developing the plan.)...." On 11-14-14 at 2:00 P.M., an interview was conducted with the Administrator, the Director of Nursing, the Restorative Nurse and			

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	the MDS nurse. The Restorative Nurse indicated the assessment for a restorative program starts with the CNA's filling out the section "What the Resident Can Do" then the Restorative Nurse assessed the resident to find out the reason and why the physical help was needed. The Restorative Nurse further indicated she placed a check in a box indicating the resident had certain "mental errors" or "physical limitations". The group had no answer as to when or how a resident's incontinent episodes were assessed. The group were asked if they had any other documentation for Resident #210 or #238 to indicate a full bladder assessment was completed prior to placing the resident on the restorative plan after each resident's bladder continency declined. No new information was given. On 11-14-14 at 2:15 P.M., the Restorative Nurse provided a Nursing Admission Assessment, dated 7-7-14, for Resident #238. The assessment indicated the resident was continent of bladder and wore no protective undergarments. The family indicated the resident may dribble urine at times. There was no assessment complete after the resident was noted to have become incontinent. 3.1-41(a)(2)			

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F000329 SS=D	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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interviews, the facility failed to ensure there was adequate monitoring of medical and/or behavioral symptoms for which a psychotropic medication was given for 1 of 5 residents reviewed for unnecessary	F000329	**F 329 Drug Regimen is free from unnecessary drugs** Resident #166 receives Risperdal 0.25 mg twice daily. Resident continues	12/10/2014

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	medications. (Resident #166) Finding includes: On 11/13/14 at 10:40 A.M., record review indicated, Resident #166 was admitted to the facility on 12/15/11, with diagnoses including but not limited to, "...hypothyroidism, hypertension, psychotic disorder with delusions, generalized pain and Alzheimer's disease...." The quarterly MDS (Minimum Data Set) assessment, completed on 8/27/14, indicated Resident #166 was severely cognitively impaired. A nursing note, dated 2/3/14, indicated "...Res (resident) is getting more combative with care...." A nursing note, dated 3/19/14, indicated "...She is hitting hard to the point where 2 aids still have problems...." A nursing note, dated 5/17/14, indicated "...At 7:30 P.M. resident entered into resident 61440 room and began going thru this resident's possessions...." An electronic behavior tracking note, dated June 2014, indicated the resident had hallucinations 3 times. A behavior		to exhibit wandering and resistance to care. Staff will continue to speak in a calm tone of voices and re-direct as needed. Licensed nursing staff will document in the ID notes when an episode takes place. CNA staff will document in the behavioral/mood monitoring section of the Point of Care Charting. Resident #166 behaviors and medications are reviewed by the Behavior Team. All care plans of residents who exhibit behavioral issues and are on anti-psychotic medications were reviewed and revised as needed. NTL and Social Services staff were in-serviced and re-educated regarding behavior monitoring and anti-psychotic medication monitoring (Attachment M). CNA staff w ill document in the behavioral/mood monitoring section of the Point of Care Charting. Licensed nurses and social workers were in-serviced and re-educated on documentation in the ID	

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	tracking note, dated July 2014, indicated the resident had hallucinations/delusions 3 times. A behavior tracking note, dated August, September and October 2014, indicated no hallucinations or delusions. A physician progress note, dated 7/7/14, indicated ..."staff report pt (patient) was on Haldol [antipsychotic medication], was stopped in February 2013 as pharmacy recommendation, was not having behaviors. Has been hitting more, family notes behaviors also. Resistant to care...Plan: begin Risperdal [antipsychotic medication] 0.25 mg [milligrams] BID [twice daily]. Call if no better...." A physician order, dated 7/8/14, indicated "...Risperdal 0.25 mg tablet PO (oral) twice daily...." A nursing note, dated 7/11/14, indicated "Resident noted to be in dining room taking personal belongings from other residents and refusing to return them. Argumentative and swatting in the direction of other residents without contact. Difficult to re-direct." A nursing note, dated 7/12/14, indicated "Resident combative tonight with staff care. Staff attempt to calm and redirect but resident continues to fight during		notes of behaviors and interventions. The Social Service Director and Nurse Team Leader or designee(s) will monitor the 24 hour report book for any behaviors and appropriate documentation/intervention s. The Behavior Monitoring Team (social services, nursing, consultant pharmacist) will meet monthly to discuss residents receiving antipsychotic medications. Notes from behavior team meeting will be forwarded to the Social Service Director after each meeting. The Social Service Director or designee will report findings to the QAPI committee quarterly for review and recommendations. Alleged date of compliance 12/10/2014.	

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	brief changes." A care plan, dated 10/31/13, indicated the problem: Dementia attributes to lack of comprehension which leads to behavioral issues: resisting care, physical and verbal aggression and wandering. Difficult to redirect. Receives medication to promote cooperation and a calm response. Interventions included but were not limited to "...Talk to [resident name] before beginning care to put her in a pleasant frame of mind. If she resists care change caregivers or come back after a brief period of time...Attempt to divert her attention to something else if she begins to enter other resident's rooms...Encourage [resident name] to attend activities to assist her in staying occupied...Use stop signs on other residents doors to discourage her entry in other rooms. If needed, place [resident name] on timed checks to ensure safety and less intrusiveness...Continue use of medication for behavior stability, monitoring for effectiveness and making changes as appropriate...." During an interview on 11/13/14 at 10:45 A.M., LPN #1 indicated, the resident did wander into other residents rooms but she does not do that anymore. She further indicated the resident is combative at times with care and does not recall the			

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	resident having any hallucinations or delusions. During an interview on 11/13/14 at 10:55 A.M., CNA #2 indicated, the resident is combative with care at times. The CNA further indicated if the resident did have any behaviors she would tell the nurse and document the behavior in the electronic record under the behaviors section. CNA #2 also indicated other than resistance to care she is unaware of any other behaviors the resident has. During an interview on 11/13/14 at 2:50 P.M., the SSD (Social Service Director) indicated, the resident did have hallucinations on June 19th, 23rd and 25th 2014 and she also had hallucinations on July 11th, 17th and 21st 2014. The SSD indicated when she reviewed the electronic documentation under the behavior section nothing was documented regarding what type of hallucination the resident was having or what interventions were attempted. The SSD indicated there was no documentation in the nurses notes regarding the hallucinations on the above dates. The SSD further indicated it is her expectation when a resident has a behavior that the behavior and the interventions that were attempted be documented in the electronic record			

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	under the behavior section. The behavior should also be documented in the nurses notes, and unfortunately that did not happen. On 11/14/14 at 9:30 A.M., a review of the current policy titled "Behavior Management and Monitoring Program" received from the Social Service Director indicated "...Behavior protocols: Educate all nursing personnel on how to document behaviors on the kiosks...Check the behavior management section of care tracker on the kiosks daily...Procedure:...The kiosks will be used to document each observed episode of the targeted behavior. It will record the following information: Date, time, behavior, precipitating events, staff intervention and outcome...." On 11/14/14 at 9:40 A.M., a review of the current policy titled "Medication Antipsychotic Drug Reduction" received from the Social Service Director indicated "...3. The resident's physician provides a justification why the continued use of drug and the dose of the drug is clinically appropriate. The justification shall include a: 1. Diagnosis, but not simply a diagnostic label or code, but the description of symptoms...." 3.1-48(a)(6)			

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F000371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to ensure sanitary food handling and serving practices related to handwashing were maintained for 1 of 3 dining rooms. (Patio dining room) Finding includes: During observation the noon meal for the Patio dining room, conducted on 11/05/2014 at 11:30 A.M., revealed dietary employee #35 was gathering dirty dishes and taking them into the kitchen	F000371	**F 371 Food Procure/Store/Prepare/Serve-Sanitary** Employee #35 was counseled on proper hand washing and safe food handling. Employee #35 verbalized an understanding. All dietary staff were in-serviced and re-educated on proper hand washing and safe food handling (Attachment J). Culinary services reviewed and revised the Hand Washing Policy (Attachment K.) Food services coordinators and pantry team leaders will monitor for compliance. Non-compliance	12/10/2014

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	and placing them near the dish washer. He then was noted to obtain a dish of a dessert for a resident without washing his hands. He then continued his dirty dish gathering and then stopped and assisted a resident with a clothing protector and cut up some meat without washing his hands. A second observation of the Patio dining, conducted on 11/13/14 at 11:20 A.M., indicated Employee #35 was noted to do the following: Dietary staff member, Employee #35 was noted to put on his apron and go into the kitchen, took his hat off and scratched his head, then proceeded to manipulate pans of food from the heated cart and place them onto the steam table. He did not wash his hands after rubbing his head. He was then noted to dish up a food plate and place it onto a tray in the window. Employee #35 then walked out of the kitchen with a paper in his hand and spoke with a resident about her meal choices, took a pencil and marked something on the paper for the resident. He then reentered the kitchen, walked straight to the refrigerator and obtained a bowl of salad from the refrigerator. He then proceeded to place food onto meal trays and also wiped his mouth with his hands. After placing food on a few meal		will be immediately corrected. This is on-going. Findings will be reported to the Culinary Director or designee using dietary food handling audits sheet daily (Attachment L). The Culinary Director or designee will submit a summary of findings to the QAPI committee quarterly for review and recommendation. Alleged date of compliance 12/10/2014	

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	trays, the dietary staff member left the kitchen, touched the bill of his hat several times, put his left hand on his hip, sat down at a dining table with a resident, brushed his nose several times with his right hand and wiped off his forehead with his right hand, then got up and walked back into the kitchen. He washed his hands for less than 5 seconds then went back to the steam table to prepare another meal tray. Review of a policy and procedure, titled "Infection Control", dated 01/31/11 and provided as current by the food service supervisor on 11/14/14 at 2:00 P.M., included the following: "1. Hands must be washed with disinfectant type soap whenever they are contaminated and/or dirty. This includes:...after handling hair, after handling dirty dishes, raw meat, garbage and any other activity that may contaminate food...." 3.1-21(i)(2)			
F000441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an			

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	Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to provide a sanitary environment as evidence by opened soiled linen bins, soiled wash	F000441	**F 441** The mechanical lift and all mechanical lifts were cleaned. All mechanical lifts were added to the	12/10/2014

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	basins on floor, staff exiting Biohazard room with gloves on and walked in hallway, linen carts open, and Hoyer lift in hallway soiled with debris. This had the potential to affect 189 out of 189 residents. Findings include: 1. During the initial tour on 11-5-14 at 10:40 A.M., a Hoyer lift was observed, on the North Unit, to have a peanut and other debris on the foot stand. The Hoyer's handles appeared to have a white dried substance on each handle. On 11-5-14 at 12:12 P.M., a Hoyer lift (mechanical lift) was observed to have debris on the foot pedal. 2. On 11-12-14 at 9:35 A.M., Housekeeper #11 was observed coming out of a soiled utility room with gloved hands. The Housekeeper #11 walked over to a resident's walker, with her contaminated gloved hands, she pushed the walker over to a resident. The Housekeeper was observed walking down the hallway and was asked to remove her contaminated gloves. The Housekeeper indicated she was on her way to remove the gloves and wash her hands.		cleaning schedule for routine cleaning (Attachment M). Housekeeper #11 was counseled on infection control procedures and donning of gloves. Housekeeper #11 verbalized an understanding. All clean wash basins will be placed in each resident room or will be stored in the supply area until ready to use. All dirty wash basins will be taken to the dirty utility room for sanitation. All linen barrel covers have labels alerting staff (Attachment M)"Do not place dirty basins on or on the floor" and "snap lid shut". Staff were reminded to make sure linen closet doors were closed after each use. All staff were in-serviced and re-educated regarding infection control procedurs, donning of gloves, basin procedures (clean and dirty), linen barrel cover closure, and linen closet doors (Attachment N). Nurse Team Leader or designee will make sure	

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	During an interview, on 11-12-14 at 9:37 A.M., Housekeeper #11 indicated she had came from the soiled utility room with gloved hands and had given a resident her walker, touching the resident's walker handles. The Housekeeper #11 further indicated she should of removed the gloves and washed her hands prior to handling the resident's walker. During an interview, on 11-12-14 at 9:50 A.M., LPN #12 indicated the soiled utility room had a wash basin for staff to remove gloves and wash their hands, before exiting the room. 3. On 11-12-14 from 9:00 A.M. thru 9:45 A.M. an observation of all units indicated wash basins were left on the hand rails in the hallway. During an interview, on 11-12-14 at 9:10 A.M., QMA #14 indicated the wash basins were placed outside of resident rooms on the railing, to indicate to the staff which resident still needed to be cleansed for the day. The following room numbers had wash basins placed on the railing: #245, #243, #135, #132,#123, and #127. On 11-12-14 at 9:20 A.M., a linen cabinet door was observed to be open outside of Room #506. A soiled linen		universal precaution is practiced by staff members, correct placement of clean and dirty wash basins, linen barrel lids snapped closed, and linen closet doors closed daily. NTL or designee will correct deficiencies immediately. This is on-going. Findings will be reported to the DON or designee via the Healthcare Community Report (Attachment G) daily. The DON or designee will report findings to the QAPI committee quarterly for review and recommendation. Alleged Date of Compliance 12/10/2014.	

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	bin was observed to not be completely closed and exposing dirty linen. The soiled linen bin also had two pink wash basins lying on top of it. On 11-12-14 at 9:25 A.M., a soiled linen bin was observed to have it's lid open just outside of Room #510. A bedside table was sitting next to the bin and there were 5 pink wash basins and a urinal, sitting on the table. On 11-12-14 at 9:30 A.M., a soiled linen bin was observed outside of room 543, the bin was open and two pink wash basins were on the floor. Outside of Room #522 the linen cabinet was observed to have one door open. A soiled linen bin had three wash basins sitting on the floor beside the bin. During an interview on 11-12-14 at 9:32 A.M., CNA #13 indicated the wash basins should not be left on the floor. CNA #13 shut the linen cabinet door and indicated the door should not be left open. CNA #13 was observed to take the wash basins to the soiled utility room and placed the basins in the room, on a shelf. The door was labeled as a biohazard room. On 11-13-14 at 8:45 A.M., an observation of South Unit indicated a			

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	linen cabinet had both doors open to the hallway. During a tour, on 11-14-14 at 9:15 A.M., with the Director of Environmental Services the following was observed: wash basins on the floor and on top of the soiled linen bins, soiled linen bins not completely closed and two opened linen cabinets. The Director of Environmental Services (DES) indicated all staff were to place the soiled basins in the soiled utility room. The basins left on the rails were to be clean and ready for use, but indicated staff leaving basins on top of the bins, on the floor, etc. might make it hard for staff to know which ones were clean. The DES further indicated the rails were not the place for staff to leave clean basins. He further indicated all linen cabinets are to be closed when not in use and all linen bins should have the lid on securely. After the tour a policy regarding glove use, basin use and linen cabinet use was requested but was not provided. 3.1-18(l) 3.1-19(g)(1) 3.1-19(g)(2)			

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