

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00153837.</p> <p>Complaint IN00153837 - Substantiated. No deficiencies related to the allegations cited.</p> <p>Survey dates: September 29, 30, October 1, 2, 6, 2014</p> <p>Facility number: 000152 Provider number: 155248 AIM number: 100267510</p> <p>Survey team: Denise Schwandner, RN-TC Barbara Fowler, RN Diana Perry, RN Anna Villian, RN Diane Hancock, RN September 29, 30, October 1, 2014</p> <p>Census bed type: SNF: 79 Total: 79</p> <p>Census payor type: Medicare: 4 Medicaid: 67 Other: 8</p>	F000000		

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

TITLE

(X6) DATE

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

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F000225 SS=D	<p>Total: 79</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 15, 2014, by Janelyn Kulik, RN.</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>				

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	<p>The results of all investigations must be reported to the administrator or his 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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure prompt reporting of an allegation of abuse to the State Survey Agency for 1 of 1 allegation of abuse investigation reviewed. (Resident #8)</p> <p>Findings include:</p> <p>On 10/2/14 at 10:58 a.m., Resident #8 was observed in his room. The resident indicated that one morning he did not get a shower. The resident further indicated that the staff member who had come to provide his shower must have been mad. Resident #8 further indicated the staff member who provided the bath might have been rough with him but he wasn't sure. Resident #8 further indicated the staff members were aware of the incident because "three big bosses" had been in to speak to him about this instance.</p> <p>On 10/1/14 at 9:26 a.m., Resident #8's clinical record was reviewed. Resident #8's diagnoses included, but were not</p>	F000225	<p>1. Resident #8 unable to correct.2. All residents interviewed and physical assessments completed to determine any potential unreported abuse.3. All employees will complete Abuse Reporting In-service.4. ED or designee will in-service completion rate weekly until completed. Abuse prevention and training completed annually for all employees. QAPI review monthly for 3 months and quarterly for 6 months.IDR request - Followed ISDH Reportable Incident Policy and Elder Care Justice Act</p>	11/05/2014			

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	<p>limited to, depressive disorder, dementia without behavioral disturbances, and anxiety.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 8/29/14, indicated Resident #8's BIMS (Brief Interview for Mental Status) indicated mild cognitive impairment.</p> <p>On 10/1/14 at 10:30 a.m., the Administrator provided the events that were reported to the State. Only one event regarding Resident #8 had been reported regarding bruising. On 10/1/14 the facility had submitted a report to the State Survey Agency regarding bruises of unknown origin. The facility had determined the bruises were a result of a previous fall.</p> <p>On 10/6/14 at 10:24 a.m., the Administrator provided the "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property Guideline" policy. The policy indicated, "In an event of an alleged violation of Federal or State laws involving mistreatment, neglect, abuse, injuries of unknown source or misappropriation of property, the center investigates the alleged violation thoroughly and reports the results of all</p>						

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	<p>investigations to the Executive Director as well as to state agencies as required by state and federal law."</p> <p>On 10/2/14 at 1:18 p.m., the DoN was interviewed. The DoN indicated Resident #8 had indicated a staff member had been rough with him during a bath. The DoN indicated an investigation had been completed. The DoN indicated she would provide the investigation into the allegation.</p> <p>On 10/2/14 at 1:37 p.m., the Administrator and DoN were interviewed. They indicated on 9/30/14 they had become aware that Resident #8 had stated a staff member had been "rough" with him. They indicated upon questioning Resident #8 had indicated the "roughness" had taken place during the previous shower. The Administrator indicated CNA #3 had been immediately suspended and an investigation had begun. The Administrator indicated Resident #8 had been interviewed and indicated his hair had not been dried right. The Administrator was queried regarding reporting of the allegation of abuse to the State. The Administrator indicated he had not reported the allegation of abuse to the State, because when the Administrator questioned the resident the Administrator did not feel</p>			

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	<p>any abuse had occurred.</p> <p>On 10/6/14 at 8:38 a.m., the Administrator was interviewed. The Administrator indicated that at some time on the morning of 9/30/14 he had become aware of Resident #8's bruises. The Administrator indicated that at that time he began the investigation into Resident #8's bruises. During the investigation the resident had made an allegation of abuse, however, the allegation of abuse was not reported to the State Survey Agency. The Administrator indicated that at approximately 1:00 p.m. on 9/30/14, Resident #8 had come to the Administrator's office. At that time, the Administrator indicated Resident #8 had indicated a staff member had been "rough" with him. The Administrator indicated that the reportable regarding Resident #8's bruises had been sent the morning of 10/1/14. The Administrator indicated that he did not include the allegation of abuse with the reportable because upon further questioning Resident #8 had indicated staff had not put deodorant on correctly and had not dried his hair correctly.</p> <p>3.1-28(c)</p>			

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F000226 SS=D	<p>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 interview and record review, the facility failed to ensure the abuse policy was followed, in that , the facility did not immediately notify the State Survey Agency following an allegation of abuse for 1 of 1 allegations of abuse reviewed. (Resident #8)</p> <p>Findings include:</p> <p>On 10/2/14 at 10:58 a.m., Resident #8 was observed in his room. The resident indicated that one morning he did not get a shower. The resident further indicated that the staff member who had come to provide his shower must have been mad. Resident #8 further indicated the staff member who provided the bath might have been rough with him but he wasn't sure. Resident #8 further indicated the staff members were aware of the incident because "three big bosses" had been in to</p>	F000226	<p>1. Resident # 8, unable to correct.2. All residents interviewed and physical assessments completed to determine any potential unreported abuse.3. All employees will complete Abuse Reporting in-service.4. ED or designee will in-service completion rate weekly until completed. Abuse prevention and training completed annually for all employees. QAPI review for 3 months and then quarterly for 6 months.IDR Request - Followed ISDH Reportable Incidents Policy and Elder Care Justice Act Policy.</p>	11/05/2014

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	<p>speak to him about this instance.</p> <p>On 10/2/14 at 1:37 p.m., the Administrator and DoN were interviewed. They indicated on 9/30/14 they had become aware that Resident #8 had stated a staff member had been "rough" with him. They indicated upon questioning Resident #8 had indicated the "roughness" had taken place during the previous shower. The Administrator indicated CNA #3 had been immediately suspended and an investigation had begun. The Administrator indicated Resident #8 had been interviewed and indicated his hair had not been dried right. The Administrator was queried regarding reporting of the allegation of abuse to the State. The Administrator indicated he had not reported the allegation of abuse to the State, because when the Administrator questioned the resident the Administrator did not feel any abuse had occurred.</p> <p>On 10/6/14 at 10:24 a.m., the Administrator provided the "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property Guideline" policy. The policy indicated, "In the event of an alleged violation of Federal or State laws involving mistreatment, neglect, abuse,</p>						

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F000242 SS=D	<p>injuries of unknown source or misappropriation of property, the center investigates the alleged violation thoroughly and reports the results of all investigations to the Executive Director as well as to state agencies as required by state and federal law."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure resident choices in regards to showers were honored, for 1 of 3 residents sampled for choices, in the sample of 4 who met the criteria. (Residents #86)</p> <p>Findings include:</p>	F000242	<p>1. Resident #86 unable to correct, shower provided on 10/07/2014. Residents were interviewed to determine those affected. Showers were provided as chosen by the resident and documented. 3. Shower sheets are audited by DNS and/or designee. 4. Report to QAPI percent of shower sheets completed monthly for 3 months and quarterly for 6 months.</p>	11/05/2014			

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	<p>Resident #86 indicated during an interview on 9/30/14 at 11:08 a.m., she would like to have showers when she was scheduled to have showers, twice a week. She indicated she had only received one shower in the past week.</p> <p>Resident #86's clinical record was reviewed on 10/01/2014 9:26 a.m. The annual Minimum Data Set (MDS) assessment, dated 7/29/14, indicated the resident required supervision and one person physical assistance with personal hygiene.</p> <p>Resident #86's care plan for physical functioning deficit related to mobility impairment, dated 5/6/14, indicated she needed assistance of one with hygiene.</p> <p>The Director of Nurses (DON) provided the Bathing Type Detail report on 10/1/14 at 10:35 a.m. for September, 2014. The report indicated the resident received partial baths daily and the only dates she received showers or full bed baths were the following:            9/2/14 9:42 p.m. shower            9/4/14 9:03 a.m. full bed bath            9/10/14 10:11 p.m. shower            9/16/14 10:28 p.m. shower            9/30/14 1:03 p.m. full bed bath            9/30/14 8:51 p.m. shower</p>			

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F000282 SS=D	<p>The DON indicated she also had paper sheets the CNAs filled out when showers were given. She provided this resident's paper sheets on 10/01/2014 at 3:26 p.m. There was only one paper sheet for September and it was dated 9/16/14. Review of the records provided, at that time, indicated the resident did not receive showers according to her wishes, twice a week.</p> <p>3.1-3(p)(4)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physicians orders for 1 of 1 residents reviewed for dialysis, in that, a fluid restriction was not followed. (Resident #15)</p> <p>Findings include:</p> <p>On 10/1/14 at 11:21 a.m., Resident #15's clinical record was reviewed. Resident</p>	F000282	<p>1. Resident #15 unable to correct.2. Identify other residents with fluid restrictions and ensure doctors orders are being followed.3. DNS or designee will monitor compliance with doctors orders.4. Report to QAPI monthly for 6 months and quarterly for one year.</p>	11/05/2014

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	<p>#15 was admitted on 6/5/14. Resident #15's diagnoses included, but were not limited to, Stage 4 Chronic Kidney Disease.</p> <p>The most recent signed physician's recapitulation orders, signed 9/25/14, included, but were not limited to, 1400 ml (milliliter) fluid restriction per day.</p> <p>The MAR (Medication Administration Record) for 9/1/14 through 9/30/14, indicated on 9/3, 9/5, 9/7, 9/12, 9/16, 9/20, 9/21, 9/26, and 9/30/14, Resident #15 received greater than 1400 ml within 24 hours.</p> <p>Care plans included, but were not limited to, alteration in kidney function. The interventions included, but were not limited to, diet and fluid restrictions as ordered by the physician.</p> <p>On 10/6/14 at 3:56 p.m., the Administrator provided the "Fluid Restrictions" policy. The policy indicated the responsibility for fluid restriction allotment was to be divided between the Dining Services and the Nursing department.</p> <p>On 10/06/2014 9:56 a.m., the Dietary Manager was interviewed. The DM indicated the fluid restriction had been</p>			

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F000323 SS=E	<p>divided between nursing staff and dietary. She indicated the fluids given on the MAR were provided by the nursing staff.</p> <p>On 10/6/14 at 4:26 p.m., LPN #3 was interviewed. LPN #3 indicated if a resident had an order for a fluid restriction, the staff documented the resident's fluid intake in the MAR.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview the facility failed to ensure an environment free from accident hazards, in that, chemicals and razors were stored in resident rooms for 5 of 32 resident rooms reviewed. (Room #202, 403, 208, 216, 212)</p> <p>Findings include:</p> <p>1. On 9/29/14 at 2:51 p.m., Room #202</p>	F000323	<p>1. Razors and personal items in identified rooms were immediately corrected.2. All resident rooms will be audited for unlabeled, uncovered and inappropriate personal items. Inappropriate items will be removed. Personal items will be stored appropriately.3. Designated employees will audit resident's rooms for unlabeled, uncovered, and inappropriate personal care items 5 times a week and complete resident</p>	11/05/2014

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	<p>was observed with an unlabeled and uncovered electric razor stored in the bathroom. On 10/2/14 at 8:19 a.m., the same was observed.</p> <p>2. On 9/29/14 at 3:00 p.m., Room #403 was observed with a bottle of hydrogen peroxide stored in the bathroom and a can of Lysol stored in the resident's room. On 10/1/14 at 4:04 p.m., the same was observed.</p> <p>3. On 9/29/14 at 3:12 p.m., Room #208 was observed with petroleum jelly stored in the bathroom. A straight and electric razor were observed to be stored in the bathroom. On 10/2/14 at 8:16 a.m., the same was observed.</p> <p>4. On 10/1/14 at 12:22 p.m., Room #216 was observed with two uncovered and unlabeled razors stored in the bathroom.</p> <p>5. On 10/1/14 at 4:16 p.m., Room #212 was observed with an unlabeled and uncovered razor stored in the bathroom.</p> <p>6. On 10/6/14 at 11:39 a.m., LPN #3 was interviewed. LPN #3 indicated residents are not allowed to store chemicals and/or razors in their rooms.</p> <p>3.1-45(a)(1)</p>		<p>checklist.4. ED or designee will audit checklist 5 times weekly. QAPI Review monthly times 3 and quarterly for 6 months.</p>	

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to adequately monitor medications for 1 of 5 residents reviewed for unnecessary medications, in that, blood pressures were not assessed for PRN (as needed)</p>	F000329	<p>1. Resident #40 corrected and orders obtained for blood pressures every 6 hours to determine the need for blood pressure regulating medication.</p> <p>2. Nursing will audit monthly all resident PRN medication orders to ensure that medications are</p>	11/05/2014

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	<p>medications. (Resident #40)</p> <p>Findings include:</p> <p>On 10/1/14 at 9:09 a.m., Resident #40 was observed sitting on the edge of his bed. Resident #40 indicated it had been a good morning.</p> <p>On 10/2/14 at 7:51 a.m., Resident #40 was observed sleeping in the activity room.</p> <p>On 10/2/14 at 8:47 a.m., Resident #40's clinical record was reviewed. Resident #40's diagnoses included, but were not limited to, hypertension.</p> <p>The most recent signed physician's recapitulation orders, signed 9/28/14, included, but were not limited to, Clonidine 0.1 mg (milligrams) by mouth, every six hours as need for high blood pressure, for a systolic blood pressure greater than 170 mm(millimeters)/Hg (Mercury) and/or a diastolic blood pressure greater than 110 mm/Hg.</p> <p>On 10/6/14 at 11:33 a.m., the DoN (Director of Nursing) provided the Weights and Vitals Summary, for 9/1/14 through 9/30/14. The summary indicated Resident #40's blood pressures were documented daily.</p>		<p>given according to doctors orders.3. DNS or designee will review nursing audits by random sample.4. QAPI review of results monthly for 3 months and quarterly for 6months.</p>	

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F000431 SS=D	<p>On 10/6/14 at 9:26 a.m., LPN #4 indicated Resident #40's blood pressure was assessed daily or weekly.</p> <p>On 10/6/14 at 11:34 a.m., the DoN indicated blood pressure parameters were located with the medication order for the Clonidine.</p> <p>On 10/6/14 at 11:47 a.m., the DoN indicated blood pressures's for Resident #40 were assessed every evening when the resident's scheduled blood pressure medication was given. She further indicated if the blood pressure was elevated, the staff could administer the Clonidine every 6 hours.</p> <p>On 10/6/14 at 4:07 p.m., the DoN indicated the staff had received an order to assess Resident #40's blood pressure every 6 hours, on that day (10/6/14).</p> <p>3.1-48(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in</p>			

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	<p>sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate labeling of medication in 2 of 3 medication carts, in that, 1 resident with ophthalmic drops and 1 resident with insulin, had medications stored in the medication carts with no labels on them. (Unit 200 medication cart, Resident #74, Resident # 85)</p>	F000431	<p>1. All identified unlabeled medications were labeled adequately immediately. 2. All medication storage areas will be inspected to ensure there are no unlabeled medications by 11/5/14. 3. Nursing staff will ensure all medications are labeled with resident name, date openend, and directions according to doctors orders. 4. DNS or designee will audit med</p>	11/05/2014

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	<p>Findings include:</p> <p>1. During an observation on 10/6/14 at 8:35 a.m., the 200 unit medication cart was observed to have Alphagan ophthalmic drops (a medication used for glaucoma) and Refresh ophthalmic drops (a medication used for dry eyes) for Resident #75 with no pharmaceutical labels on them.</p> <p>2. During an observation on 10/6/14 at 8:40 a.m., the 200 unit medication cart was observed to have a vial of Humalog U 100 insulin opened in a box for Resident #85 without a pharmaceutical label on it.</p> <p>During an interview on 10/6/14 at 9:35 a.m., RN #1 indicated she did not know what the policy was for medications that did not have a label on them.</p> <p>During an interview on 10/6/14 at 8:45 a.m., LPN #2 indicated he did not know what to do if a medication did not have a label on it.</p> <p>During an interview on 10/6/14 at 9:48 a.m., LPN #3 indicated medications should be labeled if they do not have a label on them. LPN #3 further indicated the unit has label paper in their printers to</p>		<p>carts weekly for 4 weeks, monthly for 3 months and quarterly for 3 months. Review of audits at QAPI monthly for 3 months and quarterly for 6 months.</p>	

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	<p>use if the medications need to be labeled.</p> <p>A policy titled, "Medication Ordering and Receiving from Pharmacy," obtained from the DoN on 10/6/14 at 10:38 a.m., indicated medications are labeled in accordance with facility requirements and state and federal laws. The policy indicated each prescription medication label should include the resident's name, specific directions for use including route of administration, the medication name, the strength of the medication, prescriber's name, date dispensed, quantity of medication, expiration date of medication, name, address, and telephone number of dispensing pharmacy, DEA number of dispensing pharmacy prescription number, accessory labels, container number, initial of dispensing pharmacist, lot number of the medication dispensed, expiration date, and manufacturer and/or distributor.</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l)</p>			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>			

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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to maintain an infection control program, in that, resident care equipment was stored improperly for 9 of 32 resident rooms reviewed. (Room #209, 216, 212, 202, 208, 105, 106, 104, 501)</p> <p>Findings include:</p> <p>1. On 9/29/14 at 11:46 a.m., Room #209 was observed. An unlabeled wash basin with two unlabeled and uncovered toothbrushes, four tubes of toothpaste and an emesis basin were observed. On 10/2/14 at 8:13 a.m., the same was observed.</p> <p>2. On 9/29/14 at 2:37 p.m., Room #212 was observed. In the bathroom two unlabeled denture cups, three unlabeled and uncovered toothbrushes, unlabeled body lotion, unlabeled cocoa butter lotion, unlabeled shampoo, and an unlabeled comb were observed. An unlabeled and uncovered bed pan was observed to be stored below the sink. A washcloth was observed to be stored in the bed pan. On 10/1/14 at 4:16 pm., Room #212 was observed again. An unlabeled and uncovered wash basin and an emesis basin was observed. Two</p>	F000441	<p>1. Rooms 209, 216, 202, 208, 105, 106, 104 and 501 storage of personal care equipment has been corrected. 2. DNS or designee will perform audits to determine other residents that may be affected by this deficiency. 3. Designated employees will audit resident personal care equipment 5 times a week for proper storage and labeling. 4. QAPI review monthly for 3 months and quarterly for 6 months.</p>	11/05/2014

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	<p>unlabeled denture cups, three unlabeled and uncovered toothbrushes, an unlabeled and uncovered razor, and an unlabeled comb were observed. Unlabeled lotion and body was were observed to be sitting on top of the sink. An unlabeled and uncovered urinal was observed to be stored on the back of the commode.</p> <p>3. On 9/29/14 at 2:44 p.m., Room #106 was observed. An unlabeled denture cup was observed in the bathroom. On 10/1/14 at 3:36 p.m., the same was observed.</p> <p>4. On 9/29/14 at 2:51 p.m., Room #202 was observed. An unlabeled emesis basin, two unlabeled and uncovered toothbrushes, two unlabeled denture cups, an unlabeled electric razor, and an unlabelled and electric razor were observed. An unlabeled and uncovered wash basin was observed on the back of the commode with a sprayer like device resting inside were observed. On 10/2/14 at 8:19 a.m., the same was observed.</p> <p>5. On 9/29/14 at 3:12 p.m., Room #208 was observed. An unlabeled and uncovered wash basin was observed. A straight and electric razor were observed to be stored inside the wash basin unlabeled and uncovered. An unlabeled</p>			

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	<p>and uncovered toothbrush, unlabeled toothpaste, and unlabeled deodorant were observed to be stored on the sink. On 10/2/14 at 8:16 a.m., Room #208 was observed again. Unlabeled and uncovered straight and electric razor, four unlabeled and uncovered wash basins, two unlabeled denture cups, and unlabeled shaving cream were observed. A razor was observed to be lying on the floor.</p> <p>6. On 9/30/14 at 9:08 a.m., Room #105 was observed. An unlabeled denture cup, an unlabeled and uncovered toothbrush, and an unlabeled hairbrush were observed in the bathroom. On 10/1/14 at 3:58 p.m., the same was observed.</p> <p>7. On 9/30/14 at 9:20 a.m., Room #104 was observed. A wash basin and a urine measuring cup were observed uncovered and unlabeled in the bathroom. On 10/1/14 at 4:04 p.m., the same was observed.</p> <p>8. On 10/1/14 at 4:04 p.m., Room #501 was observed. An uncovered and unlabeled urinal and wash basin were observed to be stored in the bathroom</p> <p>9. On 10/1/14 at 12:22 p.m., Room #216 was observed. Two unlabeled and uncovered wash basins were observed in</p>			

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F000465 SS=E	<p>the bathroom.</p> <p>10. On 10/6/14 11:39 a.m., LPN #3 was interviewed. LPN #3 indicated residents are not allowed to store razors in their rooms.</p> <p>3.1-18(b)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe and sanitary environment for 9 of 32 rooms, in that paint and drywall was chipped, cove base was detaching from the wall and dirty, and dirt and debris was built up along the edges and in the corners. (Room #209, 216, 212, 403, 208, 108, 106, 520, 502) Findings include: 1. On 9/29/14 at 11:46 a.m., Room #209 was observed. The caulking around the sink was observed to be cracked, the paint on the bathroom doorframe were</p>	F000465	<p>1. Identified rooms and areas corrected, including wall painted, core base glued down, drywall patched, caulking replaced, portable commode replaced, floor tile replaced, pull chain replaced, over bed table removed, dirt and debris removed, trash can liners placed, and bag of aluminum cans removed. 2. All rooms and common areas audited to determine if environment is safe, functional, sanitary and comfortable by ED or designee.3. Weekly routine environmental rounds by ED or designee.4. QAPI review of results monthly times 3 months and quarterly times 6 months.</p>	11/05/2014			

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	<p>observed to be chipped, the non-skid Velcro strip beside the bed were observed to be missing. On 10/2/14 at 8:13 a.m., the same was observed.</p> <p>2. On 9/29/14 at 12:22 p.m., Room #216 was observed. The cove base in the bathroom was observed to be soiled. A used medication patch was observed on the floor. Dirt and debris was observed to be built up along the edges and in the corners of the floor. On 10/1/14 at 12:22 p.m., the cove base was observed to be stained and dirt and debris was observed to be built up along the edges and in the corners.</p> <p>3. On 9/29/14 at 2:37 p.m., Room #212 was observed. The portable commode top was observed with rust and the gripper handles were observed to be off. The caulking around the base of the commode was observed to be brown. Dirt and debris was observed to be built up around the bottom of the bathroom door frame. On 10/1/14 at 4:16 p.m., Room #212 was observed again. The caulking around the base of the commode was observed to be brown.</p> <p>4. On 9/29/14 at 2:44 p.m., Room #106 was observed. A piece of the floor was</p>			

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	<p>observed missing beside the window. On 10/1/14 at 3:36 p.m., the same was observed.</p> <p>5. On 9/29/14 at 3:00 p.m., Room #403 was observed. A four inch chain was observed to turn the over bed light on and off. The bathroom door was observed with a large two inch by eight inch area chipped. On 10/1/14 at 4:04 p.m., the same was observed.</p> <p>6. On 9/29/14 at 3:12 p.m., Room #208 was observed. The drywall beside the bathroom door was observed to be chipped. The over bed table was observed with chips around the edges. The cove base was observed to be loose behind the door. Chipped paint was observed on the bedroom door frame and under the over bed light. A cup with dirty straws and spoons were observed to be stored by the sink. On 10/2/14 at 8:16 a.m., Room #208 was again observed. A cup with three spoons was observed in the bathroom. The cove base behind the door was observed to be loose. The over bed table was observed with chips around the edges. Two trash cans were observed without liners.</p> <p>7. On 9/30/14 at 8:58 a.m., Room #108 was observed. The paint on the walls was observed to be chipped and</p>			

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	<p>bubbling. On 10/6/14 at 9:45 a.m., the same was observed.</p> <p>8. On 9/30/14 at 11:03 a.m., Room #520 was observed. Dirt and debris were observed to be built up in the corners and underneath the dresser. On 10/1/14 at 4:10 p.m., the same was observed.</p> <p>9. On 10/1/14 at 4:04 p.m., Room #502 was observed. A towel was laid in front of the commode and a trash bag of aluminum cans were observed to be stored in the bathroom.</p> <p>10. On 10/6/14 at 11:39 a.m., LPN #3 was interviewed. LPN #3 indicated if there was a maintenance and/or housekeeping issue they page the department to notify them.</p> <p>11. On 10/6/14 at 11:45 a.m., the Housekeeping Manager was interviewed. The Housekeeping Manager indicated that the housekeeping staff clean horizontal surfaces, bathrooms, and mop residents rooms daily. The Housekeeping manager further indicated in the afternoon staff members completed a walk through to assess and clean areas that might have gotten dirty throughout the day. The Housekeeping Manager</p>			

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F000514 SS=D	<p>indicated the staff completed deep room cleanings every day. The Housekeeping Manager indicated during that time, staff members pulled the furniture away from the walls and completed a more thorough cleaning. 3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 3 residents reviewed for accidents, in a total sample of 35 residents reviewed, in that, documentation was lacking for bruising. (Resident #8)</p> <p>Findings include:</p>	F000514	<p>1. Unable to correct resident # 8.2. DNS or designee will audit routine skin assessments weekly to ensure documentation is complete and accurate for all identified breaks in skin integrity. 3. In-service all nursing staff on skin integrity guideline policy and procedure by 11/5/144. QAPI review of skin assessment audits monthly for 3 months and quarterly for 6 months.</p>	11/05/2014

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	<p>On 10/1/14 at 9:04 a.m., Resident #8 was observed in his room.</p> <p>On 10/2/14 at 10:58 a.m., Resident #8 was observed in his room.</p> <p>On 10/1/14 at 9:26 a.m., Resident #8's clinical record was reviewed.</p> <p>The "Nursing Notes" included, but were not limited to:            9/9/14: "Resident fell onto left knee after returning from the bathroom unassisted. Noted 1 cm [centimeter] x [by] 1 cm abrasion to knee"            9/11/14: "Fall F/U [follow-up]: Noted that on 9/9/14 Res [resident] was returning from bathroom turned to close the door and lost his balance. Res denied hitting head and CNA present at time of incident. Assessment completed noted 1 cm x 1 cm abrasion to left knee with edema present."            9/12/14: "Last day for f/u fall. No ill effects noted...area to knee healing ..."            9/22/14: "Resident noted to have scattered dark bruising on left side of abdomen, from top of of[sic] ribs at left underarm, down oblique waist".            9/30/14: "CNA called this nurse to resident's room....resident found to have several bruises on lt [left] side of ribs...."</p> <p>The "Resident Shower Sheet/Skin</p>			

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	<p>Concern Documentation" included, but were not limited to:</p> <p>9/12/14: The form indicated the resident had a bruised area under his left underarm</p> <p>9/15/14: The comments section indicated, "Skin looks good". The form lacked documentation to indicate bruising was present.</p> <p>9/19/14: The form lacked documentation to indicate bruising was present.</p> <p>9/22/14: The form indicated the resident had a bruised area under his left underarm.</p> <p>9/26/14: The form lacked documentation to indicate bruising was present.</p> <p>9/30/14: The form indicated the resident had 7 bruised areas, located on the abdomen, both arms, and both legs.</p> <p>The "Wound Evaluation Flow Sheet" included but was not limited to:</p> <p>9/9/14: "Obtain abrasion with fall 1 cm (centimeter) by 1 cm under L [left] knee. noted red/will bruise none at present time"</p> <p>9/30/14: "Bruising lt side of ribs purple in color": measured at 9 cm by 9 cm</p> <p>9/30/14: "Bruising lt side of ribs purple in color": measured at 5 cm by 2.5 cm</p> <p>9/30/14: "Bruising lt side of ribs purple in color": measured at 6 cm by 3 cm</p> <p>9/30/14: "Bruising lt side of ribs purple in color": measured at 8 cm by 4 cm</p>			

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	<p>9/30/14: "Bruising purple in color": identified on the left interior elbow, measured at 4 cm by 2 cm</p> <p>9/30/14: "Bruising purple in color": identified on the left wrist, measured at 2.5 cm by 4 cm</p> <p>9/30/14: "Bruising purple in color": identified lower abdominal area, measured at 10 cm by 2.5 cm</p> <p>9/30/14: "Bruising purple in color": unidentified location, measured at 2 cm by 1 cm</p> <p>On 10/6/14 at 3:56 p.m., the Administrator provided the "Skin Integrity Guideline" policy, dated 6/2014. The policy included, but was not limited to, "licensed nurse to document weekly on wounds using the 'Wound Evaluation Flow Sheet'....".</p> <p>On 10/2/14 at 1:15 p.m., CNA #2 was interviewed. CNA #2 indicated Resident #8 had received bruises from a previous fall. CNA #2 further indicated she did not usually work on Resident #8's unit, and therefore charted the bruising anyway. CNA #2 indicated the bruises were a deep purple color.</p> <p>On 10/2/14 at 1:18 p.m., the DoN was interviewed. The DoN indicated Resident #8's bruised areas, noted on 9/22/14 and 9/30/14 were related to the</p>			

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F009999	<p>resident's fall on 9/9/14. The DoN further indicated the nursing staff completed weekly skin assessments.</p> <p>On 10/6/14 at 11:03 a.m., the DoN was interviewed. The DoN indicated the resident received an order for weekly skin assessments on 9/27/14. The DoN further indicated the resident's skin checks had been completed from the shower sheets prior to that day. The DoN indicated a skin assessment had been completed on Resident #8 on 9/9, 9/12, 9/22, and 9/30/14.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>	F009999	<p>1. Identified staff members received 2nd Step TB Tests.2. All employees records were reviewed to ensure that TB tests are current and complete.3. DNS or designee will review all new hired employees to ensure TB Tests are accurate and complete, within first 30 days of employment. 4. QAPI review of</p>	11/05/2014
	<p>Based on interview and record review, the facility failed to ensure that 7 of 10 staff members reviewed for Tuberculin skin test failed to be completed, in that, the staff members had not received the second (2nd) step skin test was not completed.</p>			

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	<p>Findings include</p> <p>On 10/6/14 ten (10) employee records were reviewed for the one step and second step Tuberculin skin tests. Seven (7) employees of ten (10) were found not to have the second step Tuberculin skin test administered and recorded.</p> <p>On 10/6/14 at 4:00 p.m. the Administrator indicated the employees had the 2nd step done but, there was no record of the second step Tuberculin skin test, due to a former employee whom had left, without notice on 8/14/14, and had taken records with them. All employees hired after 8/14/14 have the second step recorded.</p> <p>A policy was received from the Administrator ,on 10/6/14 at 4:41 p.m. titled "Tuberculosis Exposure Skin Control," indicating all new employees will receive a 2-step Mantoux PPD test. Step 2 should be administered 7-10 days after Step 1 if Step 1 is negative.</p> <p>3.1-14(t)(1)</p>		audits monthly times 3 months and quarterly times 6 months.		