

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2016
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NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: June 6, 7, 8, 9, 10, and 13, 2016</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Census bed type: SNF/NF: 108 SNF: 19 Residential: 43 Total: 170</p> <p>Census payor type: Medicare: 16 Medicaid: 83 Other: 28 Total: 127</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 6/15/16.</p>	F 0000	<p>R000</p> <p>This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revisions of federal and state law.</p>	

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

TITLE

(X6) DATE

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

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F 0156 SS=C Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>			

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	<p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to</p>			

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	<p>residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure the residents were aware that the State inspection survey results were available to read and where they were located, they were informed of their right to formally complain to the State Department of Health, and were given information on how to contact the State Department of Health and the Ombudsman. This had the potential to affect the 127 residents who resided in the facility. (Resident #87 and #82)</p> <p>Finding includes:</p> <p>Interview with Resident #87, the Resident Council President, on 6/13/16 at 2:50 p.m., indicated she did not know how to contact the State Department of Health, was not aware of where she could find the contact information, and could not remember the information being discussed at the resident council meetings. She further indicated she was unaware of where to find the State inspection survey results but was sure she could ask the Activity Director if she wanted to read them. She indicated she was aware of how to contact the</p>	F 0156	<p>F156</p> <p>What correctiveaction(s), will be accomplished for those residents found to have been affectedby the deficient practice.</p> <p>1. Residents # 82 and #87 received information regardingcontacting the state and location of state inspection survey results.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken:</p> <p>1. Residentsreceiving services at this facility have the potential to be affected.</p> <p>2. Audit conducted by Activity Directorto assure that residents are aware of phone numbers to contact and state andthe location of state inspection survey results.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</p> <p>1. Executive Director /designee willin-service Activity staff regarding informing resident's location of stateinspection survey results and location of phone numbers to contact the state.</p> <p>2. During resident council</p>	07/12/2016

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	<p>Ombudsman because the contact information was listed on the activity calendar but she did not think that information was discussed at the meetings.</p> <p>Resident #87's record was reviewed on 6/13/16 at 3:26 p.m. The Annual Minimum Data Set (MDS) assessment, dated 5/20/16, indicated a BIMS (Brief Interview for Mental Status) score of 15 which indicated the resident was cognitively intact.</p> <p>Interview with Resident #82 on 6/13/16 at 3:09 p.m. indicated she regularly attended resident council meetings. She indicated she was not sure how to contact the State Department of Health and could not remember that information being discussed at the meetings. She further indicated she was unaware of who the Ombudsman was or how to contact them and she did not know where the state inspection survey results were located.</p> <p>Resident #82's record was reviewed on 6/13/16 at 3:26 p.m. The Quarterly MDS assessment, dated 3/30/16, indicated a BIMS score of 15 which indicated the resident was cognitively intact.</p> <p>Review of the monthly Resident Council meeting minutes from January 2016 to</p>		<p>meetingsname and phone for the ombudsman and state will be discussed and documented inthe minutes as well as the location of the state inspection survey results.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur, i.e.,what quality assurance program will be put into place.</p> <p>1.The Activity Director/designee will audit 100%of resident council notes for six months to assure location of state inspectionsurvey book location and names with phone numbers of ombudsman and state aredocumented. Reports of the audits willbe discussed at the Quality Assurance committee meeting monthly for sixmonths. If deficiencies are noted theQuality Assurance Committee will develop a plan of action to correct andrecommend continued monitoring until corrections are effective.</p> <p>2.Completion date July 12, 2016.</p>	

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F 0225 SS=D Bldg. 00	<p>May 2016 on 6/13/16 at 2:58 p.m., indicated there was no discussion about the rights of residents to formally complain to the State Department of Health or how to contact the State Department of Health, who the Ombudsman was or how to contact them, or where the past State inspection survey results were located.</p> <p>Interview with the Activity Director on 6/13/16 at 3:04 p.m., indicated information about the how to contact the State Department of Health and the Ombudsman had not been discussed at the resident council meetings because the contact information was printed on the activity calendars that were given to residents. She further indicated she had not discussed the location of the State inspection survey results with the residents. She indicated she would start discussing the above information at the next meeting.</p> <p>3.1-4(j)(3)(C) 3.1-3(b)(1)</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,</p>				

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	<p>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> <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 record review and interview, the facility failed to ensure the Indiana State Department of Health (ISDH) was notified immediately of an allegation of verbal abuse for 1 of 1 residents reviewed</p>	F 0225	<p>Plan of Correction</p> <p>F Tag 225</p> <p>1. What corrective action(s) will be accomplished for those</p>	07/12/2016

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	<p>for abuse of the 1 who met the criteria for abuse. (Resident #96)</p> <p>Finding includes:</p> <p>A family Interview was conducted with the daughter of Resident #96 on 6/7/16 at 10:21 a.m.. Resident # 96's daughter indicated a CNA spoke badly to her mother about one week ago, and she was told that the CNA was not allowed to take care of her mother anymore. Resident #96's daughter indicated she told the Social Service Director (SSD) and the Director of Nursing (DON).</p> <p>Interview with the Reclaim Unit Manager on 6/8/2016 at 2:24 p.m., indicated the SSD should have initiated an investigation. She further indicated she did not believe it was an allegation of abuse but a difference in approach.</p> <p>Interview with the DON on 6/8/16 at 2:37 p.m., indicated she had a soft file on the concern, and it had been investigated. She indicated the Resident's Daughter had left a voice mail for the SSD on May 28, 2016 indicating that a staff member told her mother "to shut up and don't get involved in her roommate's affairs." She further indicated she did not report the concern to ISDH. She indicated the investigation was completed and found</p>		<p>residents found to have been affected by the deficient practice.</p> <p>1. Upon surveyor inquiry Resident # 96's concern was sent to state as a reportable on 6/8/16 and surveyors aware.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. Resident's care concerns reviewed for indication of allegation of abuse.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. Staff education scheduled for all management team regarding the immediate reporting of any and all allegations of abuse. Staff also educated related to thorough investigation of concerns which may indicate allegations of abuse.</p> <p>2. Directed in-service completed for Executive Director, DON/designee and Department supervisors, regarding the immediate reporting of any and all allegations of abuse to the ISDH</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will</p>	

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	<p>that CNA #2 had been taking care of the resident's roommate on the evening shift when Resident #96 needed assistance, but the resident was coded for care in pairs (two staff members at a time to care for a resident), which the resident did not understand. CNA #2 indicated she would be right back because she needed to get another staff member to help assist, and that upset the resident. The resident proceeded to tell a different CNA that evening that she would get that CNA back for not helping her. CNA #2 was removed from the floor, the roommate was interviewed and she had no complaints about any staff member. The final result was that CNA #2 was not allowed to care for Resident #96 anymore unless it was an emergency.</p> <p>Interview with the Clinical Consultant (previous Administrator) on 6/8/16 at 2:45 p.m., indicated she was aware of the incident and the allegation of abuse should have been reported to ISDH.</p> <p>Interview with the DON on 6/10/16 at 3:40 p.m., indicated she had just reported the allegation, and it should have been reported to the State when the incident occurred.</p> <p>The record for Resident #96 was reviewed on 6/8/16 at 10:57 a.m. The</p>		<p>not recur: i.e., what quality assurance program will be put into place.</p> <p>1. The Social Service director /designee will audit any concern for thoroughness, accuracy and indication of abuse. The Social Service/designee will report to QA monthly for total of six months.</p> <p>2. All allegations will be reported to ISDH by Executive Director or designee</p> <p>3. All abuse allegations will be reviewed at monthly QA times next 3 quarters</p> <p>If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p> <p>4. Completion by July 12, 2016.</p>		

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F 0226 SS=D Bldg. 00	<p>resident's diagnoses included, but were not limited to, orthostatic hypotension, chronic atrial fibrillation, other abnormalities of gait and mobility, muscle weakness, and cognitive communication deficit.</p> <p>The 30 day Minimum Data Set (MDS) assessment dated 4/14/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was cognitively impaired.</p> <p>3.1-28(c)</p> <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 record review and interview, the facility failed to follow their policy and procedure for reporting allegations of abuse for 1 of 1 residents reviewed for abuse of the 1 resident who met the criteria for abuse. (Resident #96)</p>	F 0226	<p>Plan of Correction</p> <p>F Tag 226</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p>	07/12/2016

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	<p>Finding includes:</p> <p>A family Interview was conducted with the daughter of Resident #96 on 6/7/16 at 10:21 a.m.. Resident # 96's daughter indicated a CNA spoke badly to her mother about one week ago, and she was told that the CNA was not allowed to take care of her mother anymore. Resident #96's daughter indicated she told the Social Service Director (SSD) and the Director of Nursing (DON).</p> <p>Interview with the Reclaim Unit Manager on 6/8/2016 at 2:24 p.m., indicated the SSD should have the investigation. She further indicated she did not believe it was an allegation of abuse but a difference in approach.</p> <p>Interview with the DON on 6/8/16 at 2:37 p.m., indicated she had a soft file on the concern, and it had been investigated. She indicated the Resident's Daughter had left a voice mail for the SSD on May 28, 2016 indicating that a staff member told her mother "to shut up and don't get involved in her roommate's affairs." She further indicated she did not report the concern to ISDH. She indicated the investigation was completed and found that CNA #2 had been taking care of the resident's roommate on the evening shift when Resident #96 needed assistance, but</p>		<p>1.Uponsurveyor inquiry Resident # 96's concern was sent to state as a reportable on6/8/16 and surveyors aware.</p> <p>2.Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:</p> <p>1.Residentscare concerns reviewed for indication of allegation of abuse. No abuse indicated after care concerns werereviewed.</p> <p>3.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</p> <p>1.Scheduledstaff education prior to the start of their shift regarding the Immediate reporting of allegation of abuse or related careconcern related to abuse.</p> <p>2.Re-educationof Executive Director, DON/designee related to thorough investigation of concernswhich may indicate allegations of abuse according to Resident abuse investigationpolicy.</p> <p>4. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur: i.e., whatquality assurance program will be put</p>	

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	<p>that resident was coded for care in pairs (two staff members at a time to care for a resident), which the resident did not understand. CNA #2 indicated she would be right back because she needed to get another staff member to help assist, and that upset the resident. The resident proceeded to tell a different CNA that evening that she would get that CNA back for not helping her. CNA #2 was removed from the floor, and the roommate was interviewed and she had no complaints about any staff member. The final result was that CNA #2 was not allowed to care for Resident #96 anymore unless it was an emergency.</p> <p>Interview with the Clinical Consultant (previous Administrator) on 6/8/16 at 2:45 p.m., indicated she was aware of the incident and the allegation of abuse should have been reported to ISDH.</p> <p>Interview with the DON on 6/10/16 at 3:40 p.m., indicated she had just reported the allegation, and it should have been reported to the State when the incident occurred.</p> <p>The record for Resident #96 was reviewed on 6/8/16 at 10:57 a.m. The resident's diagnoses included, but were not limited to, orthostatic hypotension, chronic atrial fibrillation, other</p>		<p>into place.</p> <p>1. The Social Service director /designee will audit any concern for thoroughness, accuracy and indication of abuse. The Social Service/designee will report to QA monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p> <p>1. Completion by July 12, 2016.</p>	

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F 0280 SS=D	<p>abnormalities of gait and mobility, muscle weakness, and cognitive communication deficit.</p> <p>The 30 day Minimum Data Set (MDS) assessment dated 4/14/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was cognitively impaired.</p> <p>The current policy with revision date of 2/22/13 was reviewed on 6/10/16 at 3:45 p.m. Review of the "Resident Abuse Investigation" policy, received from the DON on 6/10/16 at 3:30 p.m., indicated "...6. The Abuse Prevention Coordinator or his/her designee will notify the State regulatory agency and the facility licensee via facsimile (with confirmation of receipt attached to the retained fax) of the alleged abuse immediately not to exceed 24 hours of the receipt of the allegation...."</p> <p>3.1-28(a) 3.1-28(c)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING</p>						

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Bldg. 00	<p>CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident had an accurately updated care plan related to a pressure ulcer for 1 of 20 residents whose care plans were reviewed. (Resident #18)</p> <p>Finding includes:</p> <p>On 6/8/16 at 4:32 p.m., Resident #18 was observed in her room receiving wound care with the Wound Nurse. The Wound Nurse had completed wound care to an unstageable pressure ulcer on the resident's left heel.</p> <p>Record review for Resident #18 was completed on 6/7/16 at 2:18 p.m. The</p>	F 0280	<p>F280 updated 7/8/16</p> <p>What corrective action(s), will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1. The cited comprehensive care plan R#18's has been updated to reflect current status (state/location) of pressure ulcer.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. Residents within the facility who have pressure ulcers/wounds and other conditions have the potential to be affected by the same practice.</p> <p>2. RAC's will review wound</p>	07/12/2016

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	<p>resident's diagnoses included, but were not limited to diabetes mellitus, peripheral vascular disease and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 4/20/16 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The assessment indicated the resident had 1 unstageable pressure ulcer.</p> <p>A Care Plan dated 3/9/16 indicated the resident had a blister to the left heel. Interventions included to follow up with the wound doctor as needed, measure weekly and update doctor as needed.</p> <p>A Wound Care Special Evaluation completed on 2/23/16 indicated the resident had a Stage 2 pressure ulcer to the left heel. The wound was a fluid filled blister.</p> <p>A Wound Care Special Evaluation completed on 3/8/16 indicated the wound was an unstageable pressure ulcer due to necrosis (dead tissue) to the left heel.</p> <p>The record lacked any indication the Care Plan had been updated from the resident having a blister to the left heel to then</p>		<p>report aswell as resident admission assessment and confirm that every residentidentified to have a pressure ulcer (or other wound) on the wound report or other identified conditions has an accurate careplan which reflects current status.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</p> <ol style="list-style-type: none"> Any careplan not accurately coded in any area will be corrected and submitted. The RAC(s) will review allnew/readmit resident admission assessments and make additions and updates tocare plan as needed. <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur, i.e.,what quality assurance program will be put into place.</p> <ol style="list-style-type: none"> The DON/RCN/designee will conduct audits toconfirm that recent MDS conditions arereflected on the resident's care plan. Three(3) audits weekly for four (4)weeks, Two(2) audits weekly for four (4) weeks, one(1) audit for four(4)months. <p>Reports of these audits will bediscussed and given to Quality Assurance meeting monthly for six months. If deficiencies are noted the QualityAssurance Committee will develop plans of action to correct and recommendcontinued monitoring until corrections are effective.</p>	

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	<p>having an unstageable pressure ulcer to the left heel.</p> <p>Interview with the MDS Coordinator on 6/13/16 at 9:09 a.m., indicated the resident's care plan shpould have beed updated to indicate the resident had an unstageable pressure ulcer.</p> <p>3.1-35(d)(2)(B)</p>		<p>2. Completion by July 12, 2016.</p> <p>Updated 7/7/16 F280 What correctiveaction(s), will be accomplished for those residents found to have been affectedby the deficient practice. 1. The cited comprehensive care plan R#18'shas been updated to reflect current status(state/location)of pressure ulcer. How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken: 1. Residents within the facility whohave pressure ulcers/wounds have the potential to be affected by the samepractice. 2. RAC's will review wound report andconfirm that every resident identified to have a pressure ulcer (or otherwound) on the wound report has an accurate care plan which reflects currentstatus. What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur. 1. The"Wound Nurse" will provide the RAC(s) a copy of the wound report every week. 2. The RAC(s) will review the woundreport weekly and make</p>	

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F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.		additions and updates to care plan as needed based on new wounds or change in woundstatus. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur, i.e.,what quality assurance program will be put into place. 1.The DON/RCN/designee will conduct audits toconfirm the current wound status is reflected on the resident's care plan.Three(3) audits weekly for four (4) weekly, Two(2) audits weekly for four (4)weeks, one(1) audit for four(4) months. Reports of these audits will be discussed andgiven to Quality Assurance meeting monthly for six months. If deficiencies are noted the QualityAssurance Committee will develop plans of action to correct and recommendcontinued monitoring until corrections are effective. 2.Completion by July 12, 2016.	

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	<p>Based on record review, and interview the facility failed to ensure interventions and treatments were obtained for pressure ulcers, resulting in worsening of the pressure ulcers for 1 of 3 residents reviewed for pressure ulcers of the 8 who met the criteria for pressure ulcers. This failure resulted in the deterioration of a right outer ankle wound from a Stage 2 pressure ulcer to an Unstageable pressure ulcer and a right ear wound from a Stage 2 pressure ulcer to a Stage 4 pressure ulcer. (Resident #19)</p> <p>Findings include:</p> <p>1. The closed record for Resident #19 was reviewed on 6/8/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, osteoporosis and muscle contractures. The resident was admitted to the facility on 3/31/16.</p> <p>The 4/7/16 Quarterly Minimum Data Set (MDS) assessment indicated the resident was at risk for pressure ulcers, currently had one unstageable pressure ulcer and one stage 4 pressure ulcer that were present on admission.</p> <p>A care plan dated 4/1/16 indicated the resident had a pressure ulcer to her left hip and her ankle. The interventions included: "...administer treatments as</p>	F 0314	<p>F Tag 314</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>No resident was found to be affected by this practice as:</p> <p>1.Resident #96 had no pressure ulcers at the timeof her admission (3/17/16) and as noted on Admit/readmit V screener, there wereno wounds on sacrum and coccyx. Resident #96 never developed any pressureulcers during her stay and did not have pressure ulcers at the time of theannual survey.(attachment #1 & #2)</p> <p>This example should be deleted.</p> <p>2.Resident #19 was deceased at the time of thissurvey.</p> <p>1.How other residents having the potentialto be affected by the same deficient practice will be identified and whatcorrective action(s) will be taken:</p> <p>All residents whoare at risk for pressure ulcers have the potential to affected by the samepractice.</p> <p>a. Inservice Nursing Staff:</p> <p>1.Perform thorough head to toe assessment on allnew admissions to identify any wounds.</p> <p>2.Obtain appropriate order to treat any wounds identifiedduring the assessment</p>	07/12/2016

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	<p>ordered and monitor for effectiveness...low air loss mattress with bolsters..." The intervention of "protective foam boots to BLL (bilateral lower extremities). Offload pressure from R (right) ankle wound when possible" was added on 4/6/16. The intervention of "waffle foam or neck roll when in bed to offload pressure from Rt(right) ear" was added on 4/21/16.</p> <p>Review of the Admit/Readmit Screener, dated 3/31/16, indicated the resident had a stage 2 pressure ulcer to her right outer ankle measuring 3 cm (centimeters) x (by) 3 cm, a stage 4 pressure ulcer to left hip, and two stage 2 pressure ulcers to the left buttocks.</p> <p>Review of the Weekly Wound Flow Sheet, dated 3/31/16, indicated the resident had a stage 2 pressure ulcer to her right ear measuring 0.75 cm x 0.5 cm. The following note was written under the additional comments section: "Discovered small pressure area upper R (right) ear after resident admitted and family had left the building."</p> <p>Review of a Progress Note, dated 3/31/16 at 11:30 p.m., indicated "...Noted small pressure sore to R (right) inner ear, notified (name) NP (nurse practitioner) and resident's daughter..."</p>		<p>3.Document accurately the presence of any woundson the Admit/Readmit Screener.</p> <p>4.Add pressure ulcer(or other wounds) to the careplan(location/type/stage).</p> <p>5.Complete treatments as ordered. If noimprovement in the pressure ulcer in 2-3 weeks notify physician and consideralternative treatment option.</p> <p>b. Nurse Documentation Specialist/designee willreview documentation of Resident's with pressureulcers to confirm the resident has current treatment orders according to wound protocol and perform a head to toeskin check to confirm all wound are documentedand have appropriate treatment orders.</p> <p>c. Dietary recommendations will be sent to theDON/designee and dispersed to Nurse Managersto assure prompt follow-up with physician.</p> <p>1.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur.</p> <p>a. Newly admitted Residents will be re-assessedby nurse manager/Nurse Documentation Specialistto assure that all wounds have been identified, documented and treatments have been ordered/initiated.</p>				

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	<p>Review of the Physician Admission Note, dated 4/1/16, indicated the resident had a pressure ulcer of the left hip with a wound vac and the wound doctor was to consult.</p> <p>Review of the Wound Care Specialist Evaluation, dated 4/5/16, indicated the resident had a stage 4 pressure ulcer to the left lateral hip and the pressure ulcer to the right lateral ankle was now an unstageable due to necrosis (dead tissue) measuring 2 x 0.8 x 0.2 cm. The right ankle wound was 100% necrotic tissue. The Wound Doctor performed surgical debridement of the right ankle wound and recommended a treatment to the area of hydrogel, adaptic, and a protective dressing daily.</p> <p>Review of the Wound Care Specialist Evaluation, dated 4/12/16, indicated the pressure ulcer to the right lateral ankle was now a stage 3 and measured 1 x 1 x 0.2 cm. The wound was 30% yellow necrotic tissue and 70% granulation tissue. Surgical debridement was performed to the area and the same treatment was continued.</p> <p>Review of the Wound Care Specialist Evaluation, dated 4/19/16, indicated the right lateral ankle pressure ulcer was a</p>		<p>b. DON/designee will monitor during morning meetings prompt follow-up of dietary recommendations within 48-72 hrs.</p> <p>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>1. The DON/RCC/designee will perform an audit involving dietary recommendations and re-assessment of resident and record related to wound assessment to ensure that they are followed through appropriately. All records and re-assessment of skin conditions and dietary recommendations will be audited weekly for four weeks. Two (2) audited weekly for four (4) weeks, then one (1) weekly for five (5) months. Randomly audits will then continue to assure compliance. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p> <p>2. Completion by July 12, 2016.</p> <p>INFORMAL DISPUTE RESOLUTION Crown Point Christian Village</p>	

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	<p>stage 3 measuring 1.7 x 1.5 x 0.2 cm and was 100% granulation tissue. The Wound Doctor indicated there was a generalized decline of the resident's health. The resident now also had a stage 4 pressure ulcer to the right ear measuring 2.2 x 0.7 x 0.2 cm. The evaluation indicated the area had exposed cartilage and was unavoidable secondary to rapid clinical and nutritional decline of the resident. The Wound Doctor recommended a treatment of a hydrocolloid dressing every two days and a large piece of waffle foam cut to offload the ear.</p> <p>Review of the Weekly Wound Flow Sheet, dated 4/19/16, indicated the resident had a stage 4 pressure ulcer to the right ear measuring 2.2 x 0.7 x 0.2 cm with an onset date of 3/30/16.</p> <p>Review of a Physician's Order, dated 4/15/16, indicated the resident was to receive comfort measures only and had been admitted to Hospice services.</p> <p>Review of the Hospice Physician's Order, dated 4/16/16, indicated an order for duoderm to the right earlobe stage 2 pressure ulcer every 3 days and as needed for soilage.</p> <p>Review of the March 2016 and April</p>		<p>Survey Date: 6/14/2016 F- 314</p> <p>The facility is submitting an Informal Dispute Resolution based on the following principles:</p> <p>1. R #96 does not have pressure ulcers, did not have pressure ulcers at the time of admission or at the time of survey and has not ever had a dietary recommendation for "Magic Cup" supplement as noted in the 2567.</p> <p>2. The worsening of R 19's pressure ulcers was unavoidable due to multiple co-morbidities, chronic nutritional deficit and overall deteriorating condition and was not related to the treatment of the pressure ulcer.</p> <p>R #96: R #96 is listed on the Statement of Deficiencies as being admitted on 5/26/16 but was actually admitted on 3/17/16. (See exhibit 1-Face Sheet) According to the SOD, R #96 was admitted with pressure ulcers to her sacrum and coccyx. However, documentation in R #96's health record confirms that she admitted without any pressure ulcers to sacrum or coccyx and in fact her skin integrity assessment notes only a bruise on the left ankle, a scar on her back, and a reddened area on the heel. (See exhibit 2-Admit/Readmit Screener-page 5 and 6).</p> <p>The diagnoses listed on the SOD include hyperlipidemia, arthritis,</p>	

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	<p>2016 Medication Administration Records (MAR) and Treatment Administration Records (TAR) lacked documentation the resident had received any treatment to the right lateral ankle pressure ulcer until 4/5/16 after the Wound Doctor had evaluated the area. The record lacked documentation the resident had received any treatment or intervention to the right ear pressure ulcer until 4/16/16 when ordered by Hospice.</p> <p>Interview with the Director of Nursing (DON) on 6/10/16 at 11:21 a.m. indicated she had spoken to the admitting nurse and she did not remember the resident having a pressure ulcer to her right ear on 3/31/16. She indicated she had spoken to the Wound Nurse and she did not remember finding the pressure ulcer to the resident's right ear on 3/31/16 and was unsure as to why she would have charted that. She indicated the Wound Nurse told her "I don't know what to tell you" and if the resident had the area to her right ear on 4/5/16 they (the Wound Nurse and the Wound Doctor) would have assessed it on the Wound Doctor's initial visit. She indicated the Wound Nurse indicated to her the first time she was aware of the area to the resident's right ear was 4/19/16. She further indicated there was no treatment to the right lateral ankle pressure area from</p>		<p>non-alzheimers dementia and spinal stenosis. However, exhibit 3-Diagnosis Information, clearly lists an entirely different set of diagnoses (including Atrial Fibrillation, Gait and Mobility Abnormalities, Muscle Weakness, Cognitive Communication Deficit, Heart Failure, Anemia, etc.) and it does not include any of the above diagnoses as they were listed on the SOD. Further the SOD indicates that R #96 had a "Registered Dietician initial note" on 6/1/16 in which there was a written dietician recommendation for 1 Magic Cup nutritional supplement bid. However, the initial "Registered Dietician's Assessment" for R #96 is actually dated 3/23/16 and 6/1/16 does not contain a recommendation for the magic cup supplement for Resident #96. (See exhibit 4-Dietary Nutritional Assessment) Clearly, based on the above information, validated by the exhibits, the facility cannot be cited as failing to ensure interventions and treatments were obtained for prevention or treatment of pressure ulcers for R#96 or for failing to implement the dietary recommendation for the nutritional supplement because R #96 has no pressure ulcers, was not admitted with pressure ulcers, and did not have pressure ulcers at the time of the survey. Further she did not have any dietary recommendation for the Magic</p>	

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	<p>3/31/16 until 4/5/16. She indicated the resident was provided a low air loss mattress on admission and the facility had provided her with foam boots prior to 4/5/16 but it had not been documented anywhere.</p> <p>A policy titled "Wound Management", dated 1/14/14, received from the DON as current on 6/10/16 at 12:16 p.m. indicated "...3...A. Pressure Ulcers...Pressure ulcers are staged to determine the extent of tissue damage. Treatment of the ulcer, dietary management, management of tissue loads and interventions to improve tissue tolerance to pressure, friction, and shearing forces are critical components..."</p> <p>3.1-40(a)(2)</p>		<p>Cupsupplement. Therefore the facility requests that this example be completely deleted.</p> <p>R #19: The facility maintains that R #19's decline in wounds occurred due to: <ul style="list-style-type: none"> The resident's failing general condition and multiple co-morbidities exacerbated by her poor nutritional status and unwillingness to consume either a nutritional oral diet or dietary supplements caused the wound to decline. The wound on the right inner ear was in a location where there is almost microscopic differences in the depth of a stage 2 and a stage 4 making the worsening of the ulcer (from stage 2 to stage 4) a very insignificant change in the depth and over all status of the wound. The wound on the right outer ankle is also located in an area over a bony prominence where there is little to no adipose tissue and the difference between a stage 2 and stage 4 often occurs rapidly. <p>1. Resident's condition and co-morbidities: The SOD mentions only two diagnoses for R #19-osteoporosis and muscle contractures. <u>Those two diagnoses clearly do not give any insight into the resident's true condition upon admission.</u> The diagnoses list actually includes:</p> </p>	

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			<ul style="list-style-type: none"> ·Hyperosmolality and Hyponatremia ·Pressure Ulcer of right hip-stage 4 ·Contracture of muscle-multiple sites ·Muscle weakness-generalized ·Dysphagia, oropharyngeal phase ·Abscess of Tendon Sheath-lower leg ·Alzheimer's disease ·Polyneuropathy ·Osteoarthritis ·Age related Osteoporosis ·Deficiency of Vit B group vitamins ·Vitamin D deficiency ·Gastro-Esophageal Reflux disease ·Major Depressive Disorder- Recurrent ·Protein-Calorie Malnutrition <p>The facility recognizes the significance of this long list of co-morbidities and their impact on the resident's ability to heal wounds or to circumvent new wounds from occurring and questions why none of the more significant diagnoses were considered and included in the SOD. The facility notes the rationale to only include two diagnoses in the 2567 (osteoporosis and muscle contractures) which are fairly irrelevant to resident's ability to heal and avoid new pressure ulcers and clearly do not accurately illustrate R #19's physical, nutritional and mental status. <i>(Please note exhibit</i></p>	

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			<p>#5 Diagnosis List)</p> <p>Further it is noteworthy tounderstand the significance of R #19's overall nutritional status and vitamin,calorie and protein deficiencies.</p> <p>The resident was severely affectedby her chronic nutritional deficits, as evidenced by the diagnoses of Vitamin Ddeficiency, Vit B deficiency, hypernatremia, and Protein/Caloriemalnutrition. These conditions mostdefinitely make an individual at higher risk of pressure ulcers and also areknown to affect wound healing. In fact,it is implausible that a wound such as a pressure ulcer can heal or avoiddecline when the calorie and protein intake is severely diminished as it wasfor R #19. Essentially, R #19 was not able or willing to consume even 25% ofthe calories and protein needed for her to heal the pressure ulcers and theVitamin deficiencies further complicated her wound healing. (See exhibits #6 regarding the role of Vitamin deficiencies and the role of protein inwounds healing.)</p> <p>The lab values in R #19's recordalso reflect significant abnormalities that affect wound healing. Note the low Red cell counts and lowhemoglobin, which indicate that the resident was low in iron, which carries theoxygen to the tissues. Low oxygen levelscan considerably slow or cease wound healing. Additionally, the wound specialist stated thatR #19 had</p>	

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			<p>Refractory Anemia-which refers to Anemia that is unresponsive totreatment. Despite the fact that weadministered iron supplements, the low hemoglobin could not be resolved and wasinhibiting the delivery of oxygen to the tissue which in turn deterred woundhealing, making the decline of the woundunavoidable. (<i>See exhibits_#7 CBC's</i>)</p> <p>Note that the Braden Scale tomeasure pressure ulcer risk completed at time of admission showed R #19 at HighRisk for pressure ulcers due to:</p> <ul style="list-style-type: none"> ·Nevereats a complete meal. Rarely eats more than a of any food offered. Eats 2servings or less of protein (meat or dairy products) per day. Takes fluids poorly. ·CompletelyImmobile: Does not make even slight changes in body or extremity positionwithout assistance. ·Chairfast:Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. ·Problem:Requires moderate to maximum assistance in moving. The facility made attempts to mitigatethese risk factors but in light of the resident's state of health, most of therisk factors could not be substantially diminished. The facility 	

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			<p>provided a low air loss mattress, turning and positioning, appropriate vitamin/mineral supplementation, Megace to encourage appetite, Speech Therapy, Ensure and Magic Cup nutritional supplements and other appropriate interventions to enhance wound healing. The Nurse practitioner was notified of the superficial wounds on the ear and the ankle on 3/31/2016 and there were no new orders. A referral was made to a wound specialist who saw the resident within 5 days after admission and began to address the wounds as he felt was appropriate given the overall condition and terminal prognosis of the resident intensified by severe, chronic nutritional deficits.</p> <p>There is an abundance of documentation that indicates that R #19 would not eat. She would not eat solid food and often only took in small amounts of her nutritional supplements. She would close her mouth tightly indicating she did not want to eat. Occasionally a family member could entice her to consume the supplement but just as often she refused for the family as well as the staff. R #19 was in the end stage of her life and was eventually under hospice care (4/18/16). Her family adamantly refused a feeding tube after the staff explained several times how nutritionally compromised their</p>	

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			<p>mother was. The staff respected those decisions and continued to attempt to get R #19 to take nutrition orally, usually without success. (See exhibits #8 regarding nutritional intake, family refusal of feeding tube)</p> <p>The VOHRA wound physician acknowledged (as cited in the SOD) that the decline in the wounds were "unavoidable secondary to rapid clinical and nutritional decline". The physician did not indicate that the issue that caused the wound to decline was related to a treatment but to the overall condition of the resident related to her medical conditions and serious nutritional status which was chronic and irreversible given her ability and unwillingness to consume nutrients. (See exhibits #9 Wound physician visits of 4/5 and 4/20)</p> <p>1. Location of R #19's pressure ulcers.</p> <p>Both the ear and the ankle are locations that have little adipose tissue. There is no fat layer to protect the underlying tissues. This anatomical detail makes these areas vulnerable to rapid deterioration. The difference in depth between stages (2, 3 or 4) can be nearly imperceptible. The fact that the wounds progressed from stage 2 to stage 4 is not an unusual occurrence given the location of the wound, the</p>	

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F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a		<p>residents low body weight and lack of adipose tissue at these sites thatare highly susceptible to rapid deterioration and decline, even though thechange in depth is minimal.</p> <p>Summary:</p> <ol style="list-style-type: none"> 1. Example R # 96 requires deletion since R # 96did not have either pressure ulcers a dietary recommendation for "magic cup"supplement. 2. The F314 G level wascited without full consideration of the serious condition of the resident interms of her multiple co-morbidities, numerous vitamin/mineral/nutritional deficits, and her total inabilityor unwillingness to eat, all of which not only contributed to but caused decline in the status of the pressure ulcer. The decline should be deemed most definitelyunavoidable regardless of what treatment may have been ordered. There was also no regard given to thelocation of the wounds which are areas with little or no adipose tissueespecially in the case of a person who weighed only 94 pounds and wereextremely vulnerable to rapid deterioration. Therefore, the F314 (G) is notsubstantiated for R #19. 	

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	<p>resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident maintained acceptable parameters of nutrition related to following through with dietary recommendations for 1 of 5 residents reviewed for nutrition of the 5 who met the criteria for nutrition. (Resident #41)</p> <p>Findings include:</p> <p>1. The record for Resident #41 was reviewed on 6/10/16 at 2:53 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and heart disease.</p> <p>Review of the Dietary Nutritional Assessment, dated 4/28/16 and signed by the Dietician on 5/2/16, indicated the resident had no weight change, but "abnormal" albumin (protein). The note indicated a recommendation for "2.0 cal supplement (a nutritional drink) 60 ml (milliliters) two times a day for hypoalbuminemia, hypoproteinemia." The record lacked documentation to</p>	F 0325	<p>F325</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>1.Resident #96 admitted 3/17/16 has had consistentweights since her admission with no documentation of dietary interventions. This example should be deleted.</p> <p>2.Resident # 41: physician notified and dietarysupplement initiated 6/13/16.</p> <p>1.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Anyone Resident in the facility who has weightloss or a nutritional deficit has the potential to be affected by this practice.</p> <p>2.DON, RCN, VP of Nursing Services will review thedietary recommendation process with consulting dietician and Health Technologisto ensure the recommendations communicated appropriately and timely.</p>	07/12/2016

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	<p>indicate the resident received any 2.0 cal supplement.</p> <p>Review of the Dietary Nutritional Assessment, dated 5/12/16 and signed by the Dietician on 5/31/16, indicated the resident had an unplanned weight loss that was non-significant and had "abnormal" albumin. The note indicated a recommendation for "...add 2.0 cal supplement 60 ml tid (three times a day)...weekly weights x (times) 4." The record lacked documentation to indicate the resident had been weighed weekly or received any 2.0 cal supplement.</p> <p>Interview with the Eden Unit Manager on 6/13/16 at 4:18 p.m. indicated the weekly weights had not been completed because she had not seen the recommendation to weigh the resident weekly. She further indicated when she originally saw the order for 2.0 cal supplement, she had checked the ingredients and the box indicated it contained soy and milk. She indicated she questioned if the resident should have the supplement or not because the resident was lactose intolerant. She indicated she had recently learned the 2.0 cal supplement product was lactose free and the resident had started receiving the supplement today.</p> <p>3.1-46(a)(1)</p>		<p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1.Inservice DON/Nurse Managers/Dietary Supervisor on the need to process and implement Dietary Recommendations timely after they are received.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>1.DON/RCN/designee to monitor timeliness of Dietary Recommendation implementation with audit form. Five (5) audits after dietician visit for four(4) weeks, three(3) audits after dietician visit for four(4) weeks, one(1) audit after dietician visit for four(4) months to ensure continued compliance. Report results to QA meeting monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p> <p>2.Completion date by July 12, 2016.</p> <p>INFORMAL DISPUTE RESOLUTION</p>				

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	3.1-46(a)(2)		<p>Crown Point Christian Village Survey Date: 6/14/2016 F- 325</p> <p>The facility wishes to submit a refutation to deficiency F-325 regarding example R #96: R #96 does not have pressure ulcers, did not have pressure ulcers at the time of admission or at the time of survey and has not ever had a dietary recommendation for "Magic Cup" supplement as noted in the 2567.</p> <p>R #96 is listed on the Statement of Deficiencies as being admitted on 5/26/16 but was actually admitted on 3/17/16. (See exhibit 1-Face Sheet) According to the SOD, R #96 was admitted with pressure ulcers to her sacrum and coccyx. However, documentation in R #96's health record confirms that she admitted without any pressure ulcers to sacrum or coccyx and in fact her skin integrity assessment notes only a bruise on the left ankle, a scar on her back, and a reddened area on the heel. (See exhibit 2-Admit/Readmit Screener-page 5 and 6).</p> <p>The diagnoses listed on the SOD include hyperlipidemia, arthritis, non-alzheimer's dementia and spinal stenosis. However, exhibit 3-Diagnosis Information, clearly lists an entirely different set of diagnoses (including Atrial Fibrillation, Gait and Mobility Abnormalities, Muscle Weakness, Cognitive</p>	

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F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 8 residents observed during 6 medication pass observations. Two errors	F 0332	Communication Deficit, Heart Failure, Anemia, etc.) and it does not include any of the above diagnoses as they were listed on the SOD. Further the SOD indicates that R #96 had a "Registered Dietician initial note" on 6/1/16 in which there was a written dietician recommendation for 1 Magic Cup nutritional supplement bid. However, the initial "Registered Dietician's Assessment" for R #96 is actually dated 3/23/16 and does not contain a recommendation for the magic cup supplement. (See exhibit 4- Dietary Nutritional Assessment) Based on the above information, validated by the exhibits, the facility cannot be cited as failing to ensure dietician's recommendations to give Magic Cup bid to R #96 because this resident did not have any dietary recommendation for the Magic Cup supplement. Therefore the facility requests that this example be completely deleted. F 332 – updated 7/8/16 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. Resident #54 and #156 were assessed on	07/12/2016

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	<p>in medications were observed during 26 opportunities for errors in medication administration. This resulted in a medications error rate of 7.69%. (Residents #54 & #156)</p> <p>Findings include:</p> <p>1. During an observation on 06/08/16 at 5:50 a.m., RN #1 completed a glucometer test (blood sugar) on Resident #54. The result of the test was 255 (normal 70-100). RN #1 indicated she would administer the resident's insulin right before her breakfast because the resident was a "brittle diabetic".</p> <p>During an observation on 06/08/16 at 6:50 a.m., RN #1 administered Lispro (rapid acting insulin), 10 units to resident #54. RN #1 indicated the insulin onset time was 30 minutes and the resident would have her breakfast within 30 minutes.</p> <p>Resident #54 was observed on 06/08/16 at 7:15 a.m., 7:35 a.m., and 7:40 a.m. without her breakfast tray or food available to her. The resident was observed on 06/08/16 at 8 a.m. eating cereal. CNA #2 indicated the resident was served her cereal at 7:55 a.m.</p> <p>The Nursing Drug Hand Book, 2014,</p>		<p>6/8/16 to determine that they had suffered no ill effects. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. a. Residents within the facility have the potential to be affected by the same deficient practice. 3. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur:</p> <p>a. In service Nurses regarding:</p> <p>i. Administering right does – pass from the MAR note the label on the medication ii. Placing “order change” alert sticker on any med that has dosage change. iii. The onset time of insulin and the need to administer at the time the manufacturer recommends. iv. Every shift med-cart clean up. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur., i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. a. DON/RCN/Designee check all med carts for cleanliness two(2) times a week for four(4) weeks, one (1) time a week for four(4) weeks, then random spot checks for four(4) months to ensure continued compliance. b. DON/RCN/Designee to complete medication pass audits, four(4) time a week for four(4) weeks minimum</p>	

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	<p>located at the Reclaim Unit Nurses' Station, page 745, indicated lispro insulin was to be given within 15 minutes before a meal to prevent hypoglycemia.</p> <p>Resident #54's record was reviewed on 06/08/16 at 9:45 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure.</p> <p>A Physician's Order, dated 03/07/16, indicated an order for humalog insulin (Lispro) inject per sliding scale (amount of insulin by results of blood sugar), blood sugars 100-400, administer 10 units of insulin.</p> <p>During an interview on 06/08/16 at 1:10 p.m., The Director of Nursing indicated there was no facility policy on administration of insulin and rapid acting insulin should be given at least 30 minutes prior to a meal.</p> <p>2. During an observation on 06/08/16 at 8:50 a.m., LPN #3 prepared Resident #156's morning medications to be administered per the gastrostomy tube (g-tube) (feeding tube). The medications included a liquid multivitamin.</p> <p>LPN #3 poured 5 cc (cubic centimeters) of the liquid multivitamin in a plastic</p>		<p>four(4)residents(one(1) with insulin), then two (2) times a week with minimum four(4)residents(one insulin) and then random spot checks for four(4) months to ensurecontinued compliance. Medication administrationaudits to be conducted all shifts with scheduled nurses. c. Monitoring will be reviewed atmonthly QA meetings, if deficiencies are noted the Quality Assurance Committeewill develop plans of action to correct and recommend continued monitoringuntil corrections are effective. d. Completion by July 12, 2016 updated 7/7/16 F 332 1. Whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient practice:</p> <p>a. Resident #54 and #156 were assessed on 6/8/16 to determine that they had suffered no ill effects. 2. How otherresidents having the potential to be affected by the same deficient practicewill be identified and whatcorrective action(s) will be taken. a. Residents within the facility have thepotential to be affected by the same deficient practice. 3. Whatmeasures will be put into place or what systemic change will be made to ensurethat the deficient practice does notrecur:</p> <p>a. Inservice Nurses regarding:</p> <p>i. Administering right does – pass from theMAR note the label on the medication ii. Placing “order</p>		

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F 0371 SS=E	<p>medication cup. The label on the bottle of the vitamin indicated to give 5 cc's of the multivitamin daily.</p> <p>LPN #3 then administered the medications to the resident per the g-tube.</p> <p>Resident #156's record was reviewed on 06/08/16 at 9:45 a.m. The resident's diagnoses included, but were not limited to, quadriplegia and failure to thrive.</p> <p>A Physician's Order, dated 04/12/16, indicated Cerovite (multivitamin) 15 cc's per g-tube daily in the morning.</p> <p>The Medication Administration Record, dated 06/2016, indicated Cerovite, give 15 cc's per g-tube daily at 8 a.m.</p> <p>During an interview on 06/08/16 at 9:50 a.m., LPN #3 indicated 5 cc's of Cerovite was given and the label on the bottle was incorrect</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.35(i) FOOD PROCURE,</p>		<p>change" alert stickeron any med that has dosage change. iii. The onset time of insulin and the needto administer at the time the manufacturer recommends. iv. Every shift med-cart clean up. 4. How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur., i.e., what qualityassurance program will be put into place; and by what date the systemic changeswill be completed. a. DON/RCN/Designee check all med carts forcleanliness two(2) times a week for four(4) weeks, one (1) time a week forfour(4) weeks, then random spot checks for four(4) months to ensure continuedcompliance. b. DON/RCN/Designee to complete medicationpass audits, four(4) time a week for four(4) weeks minimum six(6) residents(one(1)with Sliding scale insulin), then two (2) times a week with minimum six(6)residents(one sliding scale insulin) and then random spot checks for four(4)months to ensure continued compliance. c. Monitoring will be reviewed at monthlyQA meetings, if deficiencies are noted the Quality Assurance Committee willdevelop plans of action to correct and recommend continued monitoring untilcorrections are effective. d. Completion by July 12, 2016</p>	

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NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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Bldg. 00	<p>STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper hand hygiene was completed during dining service related to touching both food and nonfood items without changing gloves in the Lower Level Dining Room which had the potential to affect 15 of 15 residents eating in the Lower Level Dining Room, staff touching food without a hairnet or gloves on when removing food from the salad bar for storage in the Main Dining Room which had the potential to affect 17 of 17 residents eating in the Main Dining Room, and uncovered refrigerated foods in the Kitchen. The facility also failed to ensure the high temperature dishwasher was at proper temperature for the rinse cycle which had the potential to affect 120 of 127 residents in the facility. (Lower Level Dining Room, Kitchen, and Main Dining Room)</p> <p>Findings include:</p> <p>1. On 6/6/16 at 11:35 a.m. the Lower Level Dining Room lunch service was observed. The dining room included 15</p>	F 0371	<p>F371 – updated 7/8/16</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. There was no negative impact and residents were not affected by the alleged practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. All residents have the potential to be affected 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Staff re-educated with regard to best practice to ensure that they store, prepare, distribute, and service food under sanitary conditions; to include proper hand hygiene, hair nets being worn at all times, and food to be covered when in the refrigerator. b. Staff will be re-educated on dishwashing temps to ensure proper temps throughout the entire cycle. c. Service man to check dish machine concluding no repairs necessary. d. A log will be kept to ensure proper temps are maintained. 4. How the corrective action(s) will be</p>	07/12/2016

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	<p>residents. The lunch menu included Chicken Fajitas. Staff members were observed taking the resident's meal tickets to each table and setting the meal tickets down at each table to write down what the residents wanted for lunch. The staff then placed the meal tickets on top of the steam table cart.</p> <p>On 6/6/16 at 11:45 a.m., Cook #1 was observed to put on a pair of gloves. The cook then proceeded to grab a meal ticket from the top of the steam table and set it down in front of her on the steam table. She grabbed a plate, removed a taco shell out of the bag, scooped out the chicken onto the taco shell with a scooper and then proceeded to wrap up the taco shell with her gloved hands. The cook proceeded to do this in between each resident's plate without changing gloves at anytime while touching the meal tickets and touching the taco shells. The cook then proceeded to take out a bun from a bun bag and placed it onto a plate. She scooped out the chicken with a scooper onto the bun and placed the top bun onto the bottom bun with the same gloved hands. The cook then proceed to open a plastic bin to get out another food scooper, she then scooped carrots onto a plate and poured chips onto a plate and then moved the chips around the plate with the same gloved hands. The cook</p>		<p>monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. a. Dietary manager/designee will observe through rounds during all meal service times to assure compliance with hand hygiene, gloves and hairnet protocols. b. Audits of temperature logs will be completed by dietary manager/designee daily. c. Monitoring of other practices conducted twice (3) weekly for four (4) weeks, two (2) times weekly for four (4) weeks and then one (1) time monthly to ensure continued compliance. Audit findings will be presented to the QA meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective. d. Completion by July 12, 2016. Updated 7/7/16 F371</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1. There was no negative impact and residents were not affected by the alleged practice.</p> <p>1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. All residents have the</p>	

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	<p>then proceeded to continue to touch residents meal tickets and roll the taco shells without changing her gloves. The cook did not use any tongs to remove the taco shells or the bun from the bag.</p> <p>Interview with Cook #1 on 6/6/16 at 11:56 a.m., indicated she was unaware while she served food behind the steam table that she was unable to touch things besides food when wearing gloves.</p> <p>Interview with the Dietary Supervisor on 6/6/16 at 3:12 p.m., indicated the cook should have not touched the non-food items and the food items with the same gloved hands.</p> <p>2. During the initial tour of the kitchen with the Food Service Manager on 6/6/16 at 9:00 a.m., the following was observed:</p> <p>a. In the stand up refrigerator 6 sandwiches were uncovered. Interview at that time with the Food Service Manager, indicated she would have to throw them out, and they should have been covered.</p> <p>The Health Technologies Guidelines and Procedure Manual dated 2011 was received from the Food Service Manager and was reviewed on 6/13/16 at 8:30 a.m. The manual indicated, "Food Storage (Dry/Refrigerated/Frozen), Section 2- Refrigerated storage guidelines to be</p>		<p>potential to be affected</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. Staff re-educated with regard to best practice to ensure that they store, prepare, distribute, and service food under sanitary conditions; to include proper hand hygiene, hair nets being worn at all times, and food to be covered when in the refrigerator.</p> <p>2. Staff will be re-educated on dishwashing temps to ensure proper temps throughout the entire cycle.</p> <p>3. Service man to check dish machine concluding no repairs necessary.</p> <p>4. A log will be kept to ensure proper temps are maintained.</p> <p>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>1. Dietary manager/designee will observe through rounds to assure compliance with hand hygiene and hairnet protocols.</p> <p>2. Audits of temperature logs will be completed by dietary manager/designee daily.</p> <p>3. Monitoring of other practices conducted twice (2) weekly for four (4) weeks, one (1) time weekly for four (4) weeks and then one (1) time monthly to ensure continued</p>	

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	<p>followed: ...Wrap food properly. Never leave any food item uncovered and not labeled."</p> <p>b. Dishwasher employee #14 ran the dishwasher through the cycle and the final rinse temperature registered 160 degrees Fahrenheit. At that time, the Food Service Manager indicated the temperature should have registered 180 degrees Fahrenheit and she would notify maintenance to look at the problem immediately.</p> <p>Interview with Maintenance employee #13 on 6/6/16 at 11:02 a.m., indicated the dishwasher was a high temperature dishwasher with a booster. Sometimes the booster dropped in temperature and needed to be adjusted. He indicated there was a temperature control on the booster which could be turned up to a higher temperature when or if the temperature dropped.</p> <p>The American Dish Service Owners Manual dated 2008 was received from the Maintenance Manager and was reviewed on 6/13/16 at 2:35 p.m.. The manual indicated, "Section General, Page 3...conventional machine with 180 degree rinse..."</p> <p>3. On 6/10/16 at 1:00 p.m., an</p>		<p>compliance. Audit findings will be presented to the QA meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p> <p>4. Completion by July 12, 2016.</p>	

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	<p>observation was made of Dietary Aide #11 removing food from the main dining room salad bar. At that time, the dietary aide was not wearing gloves or a hairnet.</p> <p>Interview with the dietary aide at that time, indicated that she was taking the left over food into the kitchen where it would put it into a clean container and placed in the refrigerator to be used again.</p> <p>Interview with the Food Service Manager at that time, indicated the dietary aide should have worn a pair of gloves and a hair net while handling food.</p> <p>The Health Technologies Guidelines and Procedure Manual dated 2011 was received from the Food Service Manager and was reviewed on 6/13/16 at 8:30 a.m., The manual indicated, "Proper Hand Washing Procedure and Proper Use of Gloves, Number 7,Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break, or to go to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform, or other non-food surface, such as door handles and equipment."</p>			

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F 0431 SS=E Bldg. 00	<p>The above manual also indicated, "Hair Restraints, Number 1, ...Staff shall wear hair restraints in all food production, dishwashing and serving areas."</p> <p>3.1-19(bb) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>			

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	<p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents' medications were labeled with a resident's name, route of administration, correct dosage, and Physician's name, failed to ensure medications were stored in a clean environment, and failed to ensure an Emergency Drug (Epi-pen) (epinephrine for allergic reactions) was not expired, for 2 of 2 resident's medications, 2 of 5 Medication Carts and 1 of 3 Medication Rooms. (Medication Carts, Eden Unit- B-Hall and C-Hall, Eden Unit Medication Room, and Residents #9 & #156)</p> <p>Findings include:</p> <p>1. During an observation on 06/08/16 at 8:50 a.m., LPN #3 prepared Resident #156's morning medications to be administered per the gastrostomy tube (g-tube) (feeding tube). The medications included a liquid multivitamin.</p> <p>LPN #3 poured 5 cc (cubic centimeters)</p>	F 0431	<p>F 431 – updated 7/8/16</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The expired medication(epi-pen) was removed and returned to the pharmacy.</p> <p>b. Multivitamin order for resident #156 had change order stick applied to bottle. MAR checked to assure order was correct.</p> <p>c. Medication carts cleaned.</p> <p>d. Resident #9's OTC medication supplied by family labeled appropriately.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Residents with multi-dose bottles who have order changes have potential for same practice.</p> <p>b. Nurse managers checked OTC medications to assure they were labeled appropriately.</p> <p>3. What measures will be put into</p>	07/12/2016

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	<p>of the liquid multivitamin in a plastic medication cup. The label on the bottle of the vitamin indicated to give 5 cc's of the multivitamin daily.</p> <p>LPN #3 then administered the medications to the resident per the g-tube.</p> <p>Resident #156's record was reviewed on 06/08/16 at 9:45 a.m. The resident's diagnoses included, but were not limited to, quadriplegia and failure to thrive.</p> <p>A Physician's Order, dated 04/12/16, indicated Cerovite (multivitamin) 15 cc's per g-tube daily in the morning.</p> <p>During an interview on 06/08/16 at 9:50 a.m., LPN #3 indicated 5 cc's of Cerovite was given and the label on the bottle was incorrect</p> <p>2. During an observation on 06/07/16 at 2:22 p.m., the Eden Unit B-Wing cart had a clear, thick, sticky substance on the bottom of the drawer and on the bottles of medication stored in the bottom drawer of the Medication Cart.</p> <p>LPN #4 indicated at the time of the observation, something must have spilled. She indicated the Night Shift staff were responsible for cleaning the</p>		<p>place or whatsystemic changes will be made to ensure that the deficient practice does notrecur:</p> <p>a. Inservicenurses: proper labeling of OTC meds brought in for a resident by family,placing "order change" alert sticker to any med that has a dosage change,checking cart/med room/cabinets for expired medication and cleanliness ofmedication carts.</p> <p>4. How the corrective action(s) will be monitoredto ensure the deficient practice will not recur: i.e., what quality assurance program willbe put into place.</p> <p>a. DON/RCN/designee will audit forcompliance the medication rooms and medication carts for "order change labels",proper labels on OTC medication and cleanliness of medication carts. . All audits will be conducted two (2) time perweek for four(4) weeks, one (1) time per week for four(4) weeks, then randomlyfor four(4) months to ensure continued compliance. Reports to QA committeemonthly for total of six months. If deficiencies are noted the QualityAssurance Committee will develop plans of action to correct and recommendcontinued monitoring until corrections are effective.</p> <p>b. Completion by July 12, 2016.</p>	

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	<p>Medication Carts.</p> <p>3. During an observation on 06/07/16 at 2:25 p.m., there were unlabeled bottles of aspirin 81 mg (milligram), Preservision (vitamin), and Extra Strength Tylenol located in a drawer in the Eden Unit-B-Hall Medication Cart. LPN #3 indicated Resident #9's family supplied the medication and labels were not placed on the bottles.</p> <p>During an observation on 06/08/16 at 8:05 a.m., there were unlabeled bottles of aspirin 81 mg and Extra Strength Tylenol located on top of the Eden Unit-B-Hall Medication Cart. LPN #3 indicated the medications were still not labeled and she would label the bottles immediately.</p> <p>4. During an observation on 06/07/16 at 2:40 p.m., there was a box with two syringes labeled "Epi-pen" in the Eden Unit Medication Room. The expiration date on the box was 05/2016. LPN #3 indicated the Epi-pens were house stock for emergency use.</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(o)</p>		<p>Updated 7/7/16</p> <p>F 431</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>1.The expired medication was removed and returnedto the pharmacy.</p> <p>2.Multivitamin order for resident #156 had changeorder stick applied to bottle. MARchecked to assure order was correct.</p> <p>3.Medication carts cleaned.</p> <p>1.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Residents with multi-dose bottles who have orderchanges have potential for same practice.</p> <p>2.Nurse managers checked OTC medications to assurethey were labeled appropriately.</p> <p>1.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur:</p> <p>1. In servicenurses: proper labeling of OTC meds brought in for a resident by family,placing "order change" alert sticker o any med that has a dosage change,checking car/med room/cabinets for expired</p>	
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F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it -		medication. 1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place. 1.DON/RCN/designee will audit for compliance the medication rooms and medication carts for "order change labels", proper labels on OTC medication and cleanliness of medication carts. . All audits will be conducted two (2) time per week for four(4) weeks, one (1) time per week for four(4) weeks, then randomly for four(4) months to ensure continued compliance. Reports to QA committee monthly for total of six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective. 2.Completion by July 12, 2016.	

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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to maintain proper infection control practices related to the storage of a resident's bedpan, toothbrushes, and personal care items for 1 of 3 Units. (Reclaim Unit)</p> <p>Findings include:</p> <p>During the Environmental Tour, on 06/08/16 at 10:35 a.m. through 11:20 a.m., with the Director of Housekeeping,</p>	F 0441	<p>F 441</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>No residents wereadversely affected by this action as it relates to infection control.</p> <p>1.Reclaim room 259 unlabeled emesis basin withtoothbrush removed when identified. 2.Unlabeled Personal care</p>	07/12/2016

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	<p>Director of Maintenance, and Administrator present, the following was observed:</p> <p>Reclaim Unit:</p> <p>a. There was an emesis basin which contained an uncovered toothbrush with no name sitting on the side of the sink and a bedpan stored on the shower seat in the bathroom of room 259. There were two residents who resided in the room.</p> <p>b. There were unlabeled personal care supplies, soap and lotion stored in the shower and a bath basin on the floor in the bathroom of room 265. There were two residents who resided in the room.</p> <p>c. There were personal supplies which consisted of deodorants, lotions, loofa, and hair conditioner, which had a resident's name who did not reside in the room, stored in an unlabeled bath basin in the shower in room 269. There were two residents who resided in the room.</p> <p>During the observations, the Director of Housekeeping indicated the CNAs are responsible to ensure resident care items are sanitary and stored properly.</p> <p>3.1-18(a)</p>		<p>supplies of soap, lotion, and bath basin removed from room 265.</p> <p>3. Personal care supplies in room 269 removed when identified.</p> <p>1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. All residents have potential to be affected by this practice.</p> <p>2. Residents received new labeled materials which were placed in plastic bags/containers and placed in their nightstand or shelf of closet.</p> <p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. Re-educate nursing staff (CNA's/Nurses) related to:</p> <p>1. Unlabeled or uncovered toothbrushes, emesis basin, soap, lotion and bedpans.</p> <p>2. Following proper infection control practices related to personal items to provide a safe clean environment to prevent infection.</p> <p>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p>	

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F 0465 SS=B Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to provide a safe, sanitary, and comfortable environment for residents, related to cracked and torn floor mats, a gouged window sill, duct tape used for toilet seat padding, torn foam, bubbled paint and a rusted commode, for 2 of 4 units. (Reclaim and Eden Units) Findings include:	F 0465	1.DON/RCN/Designee will conduct audits to assure compliance as it relates to personal care items to prevent spread of infection. Audits completed on Ambassador rounds three(3) times weekly for four(4) weeks, two(2) times per week for four(4) weeks and one (1) time per week for four(4) months, then randomly to ensure compliance. Reports of the audits will be reported to the QA meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until corrections are effective. 2.Completion by July 12, 2016. Plan of Correction F 465 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Reclaim Unit: 1.Cracked mat for floor by bed 256B was removed and	07/12/2016	

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	<p>During the Environmental Tour, on 06/08/16 at 10:35 a.m. through 11:20 a.m., with the Director of Housekeeping, Director of Maintenance, and Administrator, the following was observed:</p> <p>1. Reclaim Unit:</p> <p>a. There was a mat for the floor that was cracked and torn by the bed in 256B. There were two residents who resided in the room. The Director of Housekeeping indicated the CNA's were responsible for reporting this to Housekeeping.</p> <p>b. There was a gouge with missing veneer out of the window ledge in room 265B. There were two residents who resided in the room</p> <p>c. There was brown duct tape wrapped around the toilet seat and arms of the seat of an over the toilet commode, which was stored in the resident's shower in room 268B. The foam covering the legs of the commode was torn and the red tape on the floor shower ledge was torn and tattered. The Director of Maintenance indicated he was instructed to put the tape on the seat for a cushion due to a resident's risk for injury and there was no other padding available for the toilet seat.</p>		<p>replaced with new mat by that afternoon by the hospice company owning it.</p> <p>2. Windowsill with gouge was removed within the hour and sent out for repair. Received back and reinstalled the next day.</p> <p>3. Toilet seat over commode was removed and disposed of in the dumpster.</p> <p>Eden Unit:</p> <p>1. Wall sanded and repainted in 130B bathroom the same day.</p> <p>2. Over the toilet commode in bathroom of room 146B was removed, disposed of and replaced with newer aluminum model.</p> <p>1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. An audit of all resident rooms was made by Maintenance Director for similar problems or concerns.</p> <p>2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. All Maintenance and Housekeeping staff will be retrained on what to look for in resident rooms and writing work orders.</p>	

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F 9999 Bldg. 00	<p>The Director of Maintenance indicated the tape had started to come loose on the seat. There was one resident who resided in the room.</p> <p>2. Eden Unit:</p> <p>a. The wall above the toilet had bubbled paint in the bathroom of 130B. There were two residents who resided in the room. The Director of Maintenance indicated the wall "must have gotten wet".</p> <p>b. The over-the-toilet commode had rusted legs and bars in the bathroom of 146B. There were two residents who resided in the room.</p> <p>During an interview at the time of the observations, the Director of Maintenance indicated he completed visual checks twice daily and the staff also placed work orders if they noticed something that needed to be repaired.</p> <p>3.1-19(f)</p> <p>3.1-14 Personnel</p>	F 9999	<p>4. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur: i.e., whatquality assurance program will be put into place.</p> <p>1.The Maintenance director or his designee will auditall rooms once weekly for similar problems and concerns.The Maintenance Director or his designee will report to QA monthly for atotal of six months.</p> <p>2. Ifdeficiencies are noted the Quality Assurance Committee will develop plans ofaction to correct and recommend continued monitoring until corrections areeffective.</p> <p>3.Completion by July 12, 2016</p> <p>Plan ofCorrection F 9999</p>	07/12/2016

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	<p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:</p> <p>(6) Position in facility and job description</p> <p>(7) Documentation of orientation to the facility and to the specific job skills.</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment...The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes:</p> <p>(A) a report of the preemployment physical examination;</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a</p>		<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1.LPN #8 will have the six hours and CNA #9 will have 3 hours of dementia specific training completed by July 1, 2016.</p> <p>2.LPN #5 and Cook #7 will have required 1st and 2nd steps of mantoux completed by July 1, 2016.</p> <p>3.Executive Director had physical exam completed on June 17, 2016.</p> <p>4.LPN #5, Life Style Assistant #6 and Cook #7 will have job specific orientation completed by July 1, 2016.</p> <p>5.Life Style Assistant #6 will be given job description by July 1, 2016.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what action(s) will be taken:</p> <p>1.Any new hire will complete their required three or six dementia specific training within the first 60 days of employment, and verified by Human Resources Coordinator and Executive Director.</p> <p>2.Any new hire will complete their 2step mantoux completed within the first 3 weeks and verified by Human Resources Coordinator and Executive Director.</p> <p>3.Any new hire will complete</p>	

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	<p>minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure personnel records were complete, related to mantoux (tuberculosis testing) testing, job specific orientation, job descriptions, physical exam, and dementia training, for 6 of 11 employee files reviewed. (LPN #5, Life Style Assistant #6, Cook #7, Executive Director, LPN #8, and CNA #9)</p> <p>Findings include:</p> <p>Employee files were reviewed on 06/09/16 at 11:00 a.m. and the following were not included in the Personnel File:</p> <p>LPN #5 (hired 04/08/16): No first and second step mantoux, no specific</p>		<p>their employee physical prior to first day of employment and verified by Human Resources Coordinator and Executive Director.</p> <p>4. Any new hire will be given a job specific orientation within the first week of employment, and verified by Human Resources Coordinator and Executive Director.</p> <p>5. Any new hire will be given their job description on their first day of employment and verified by Human Resources Coordinator and Executive Director.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>1. Managers will be responsible to assure completion of all dementia specific training using the Relias training program, mantoux is administered as required, physical is completed as required, orientation and job description are given as required.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>1. Executive Director and Human Resources Coordinator will audit new hire records monthly for compliance and other employees records quarterly to assure their compliance with dementia training, mantoux testing, physical completion, and</p>	

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	<p>orientation.</p> <p>Life Style Assistant #6 (hired 03/08/16): no job description, no specific orientation.</p> <p>Executive Director (hired 03/14/16): No physical exam.</p> <p>Cook #7 (hired 04/25/16): no first and second step mantoux, no specific orientation.</p> <p>LPN #8 (hired 07/07/15): six hours of dementia training had not been completed.</p> <p>CNA #9 (hired 08/16/01): three hours of dementia training had not been completed.</p> <p>During an interview with Human Resources on 06/09/16 at 1:07 p.m., she indicated she could not find the mantoux for LPN #5, dementia training for LPN #8 and CNA #9 had not been completed, Life Style Assistant was a new position and she was still waiting for the job description to be developed, the physical exam for the Executive Director was not required by the Corporation, the specific orientations were not completed, and the mantoux for Cook #7 had not been completed and would need to be</p>		<p>receiving orientation and job description.</p> <p>2. Completion July 12, 2016.</p> <p>3. Deficiencies noted will have an action plan completed and be discussed at the quarterly Quality Assurance Committee Meeting.</p> <p>4. Compliance of plan by July 12, 2016.</p>	

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R 0000 Bldg. 00	<p>re-started.</p> <p>3.1-14(q)(6) 3.1-14(q)(7) 3.1-14(t)(1) 3.1-14(t)(3)(A) 3.1-14(u)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 43</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 32883 on 6/15/16.</p>	R 0000	<p>R000</p> <p>This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revisions of federal and state law.</p>		
R 0214 Bldg. 00	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident's condition, or more often at the resident's or facility's request. A licensed nurse shall evaluate the nursing</p>				

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	<p>needs of the resident.</p> <p>Based on record review and interview the facility failed to ensure a resident's Service Plan had been completed as required for 1 of 7 residents whose Service Plans were reviewed. (Resident #8)</p> <p>Finding includes:</p> <p>Record review for Resident #8 was completed on 6/13/16 at 12:08 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, depression, and hypertension.</p> <p>A Service Plan for Resident #8 was completed on 2/6/15. The Service Plan included the residents's cognition, assistance with Activities of Daily Living (ADLs), and code status.</p> <p>The record lacked any indication a Service Plan had been completed since 2/6/15.</p> <p>Interview with the Assisted Living Unit Manager on 6/13/16 at 3:00 p.m., indicated he could not find documentation a service plan had been completed for the resident since February 2015. He further indicated the residents should have a Service Plan completed every 6 months.</p>	R 0214	<p>Plan of Correction – updated 7/8/16 R Tag 214</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. Resident #8 no longer resides in the facility therefore cannot be re-evaluated.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:</p> <p>a. New admission to assisted living will be evaluated upon admission, within seventy-two (72) hrs., utilizing standard facility Service plan and every six months thereafter.</p> <p>b. No other residents found affected by deficit practice.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Resident Service Director in serviced by Regional Clinical Corporate Nurse on June 23, 2016 regarding utilization of schedule device, assessment of new admissions within seventy-two (72) hrs., and need for updated service plan every six months.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>a. Resident Service Director/designee will audit new admission charts for presence of</p>	07/12/2016

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			<p>service plan within appropriate time frame.</p> <p>b. Resident Service Director will monitor the schedule device calendar for re-evaluation or updates needed for six months service plan.</p> <p>c. Monitoring/audits will be submitted to the Quality Assurance Committee for a six months period or until compliance is assured.</p> <p>d. If Deficiencies are noted, a plan of action will be completed and discussed at the monthly Quality Assurance Committee meeting</p> <p>e. Compliance of the plan by July 12, 2016.</p> <p>Updated 7/7/16 Plan of Correction R Tag 214 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #8 no longer resides in the facility therefore cannot be re-evaluated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken: a. New admission to assisted living will be evaluated upon admission utilizing standard facility Service</p>	

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R 0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency		plan and every six months thereafter. b. No other residents found affected by deficit practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Resident Service Director inserved by Regional Clinical Corporate Nurse on June 23, 2016 regarding utilization of schedule device and need for updated service every six months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. a. Resident Service Director/designee will audit new admission charts for presence of service plan. b. Resident Service Director will monitor the schedule device calendar for re-evaluation or updates needed for six months service plan updates daily. c. Monitoring/audits will be submitted to the Quality Assurance Committee for a six month period or until compliance is assured. d. If Deficiencies are noted, a plan of action will be completed and discussed at the monthly Quality Assurance Committee meeting e. Compliance of the plan by July 12, 2016.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	<p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to staff touching food without wearing gloves or a hairnet and uncovered food in the stand up refrigerator. The facility also failed to ensure the high temperature dishwasher was maintained in safe operating condition in 1 of 1 kitchens. This had the potential to affect 43 of the 43 residents who resided in the facility.</p> <p>Finding includes:</p> <p>During the initial tour of the kitchen with the Food Service Manager on 6/6/16 at 9:00 a.m., the following was observed:</p> <p>a. In the stand up refrigerator 6 sandwiches were uncovered. Interview at that time with the Food Service Manager, indicated she would have to throw them out and they should have been covered.</p> <p>The Health Technologies Guidelines and Procedure Manual was received from the Food Service Manager, and was reviewed on 6/13/16 at 8:30 a.m., dated 2011, Food Storage (Dry/Refrigerated/Frozen),</p>	R 0273	<p>Plan ofCorrection - updated 7/8/16 R273</p> <p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficientpractice: a. There was no negative impact and residents were not affected by the allegedpractice. 2. How other residents having the potential to be affected by the same deficient practice be identified and what correctiveaction(s) will be taken: a. All resident have the potential to be affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Staff re-educated with regard to best practices to ensure that they store, prepare, distribute, and serve food under sanitary conditions; to include proper hygiene, hair nets being worn at all times, and food to be covered when in the refrigerator. b. Staff will be re-educated on dishwashing temps to ensure proper temps throughout the entire cycle. c. Service man in to check dish machine concluding no repairs necessary. d. A log will be kept to ensure proper temps are maintained. 4. How the corrective action(s) will be</p>	07/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2016
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	<p>Section 2- Refrigerated storage guidelines to be followed Never, ..."Wrap food properly. Never leave any food item uncovered and not labeled."</p> <p>b. Dishwasher employee #14 ran the dishwasher through the cycle and the final rinse registered 160 degrees Fahrenheit. At that time, the Food Service Manager indicated the temperature should have registered 180 degrees Fahrenheit and she would notify maintenance to look at the problem immediately.</p> <p>Interview with Maintenance employee #13 on 6/6/16 at 11:02 a.m., indicated the dishwasher was a high temperature dishwasher with a booster. Sometimes the booster dropped in temperature and needed to be adjusted. He indicated there was a temperature control on the booster which could be turned up to a higher temperature when or if the temperature dropped.</p> <p>The American Dish Service Owners Manual dated 2008 was received from the Maintenance Manager and was reviewed on 6/13/16 at 2:35 p.m. The manual indicated, "Section General, Page 3....conventional machine with 180 degree rinse..."</p>		<p>monitored to ensure thedeficient practice willnot recur: i.e., what quality assurance program will be put into place. a. Dietary manager/designee will observethrough rounds duringall meal service times to assure compliance with hand hygiene, glovesand hairnet protocols. b. Audits of temperature logs will becompleted by dietary manager and designee, daily. c. Monitoring of deficient practicesconducted three(3) weekly for four(4) weeks, two (2) times weekly for four(4)weeks and then one (1) time monthly to ensure continued compliance Results ofaudit will be reported to QA monthly for total of six months. If deficiencies are noted the QualityAssurance Committee will develop plans of action to correct and recommendcontinued monitoring until corrections are effective. d. Compliance of the plan by July 12,2016. Updated7/7/16 Plan ofCorrection R273</p> <p>1.What corrective actions(s) will beaccomplished for those residents found to have been affected by the deficientpractice:</p> <p>1. There was no negative impact andresidents were not affected by the alleged practice.</p> <p>1. How other residents having the potential to beaffected by the same deficient practice be identified and what correctiveaction(s) will be taken:</p>	

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	<p>3. On 6/10/16 at 1:00 p.m., an observation was made of the Dietary Aide #11 removing food from the main dining rooms salad bar. At that time, the dietary aide was not wearing gloves or a hairnet.</p> <p>Interview with the dietary aide at that time, indicated that she was taking the left over food into the kitchen where it would put it into a clean container and placed in the refrigerator to be used again.</p> <p>Interview with the Food Service Manager at that time, indicated the dietary aide should have worn a pair of gloves and a hair net while handling food.</p> <p>The Health Technologies Guidelines and Procedure Manual dated 2011 was received from the Food Service Manager and was reviewed on 6/13/16 at 8:30 a.m. The manual indicated, "Proper Hand Washing Procedure and Proper Use of Gloves, Number 7,Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break, or to go to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform, or other non-food surface, such as door handles and</p>		<p>1. All resident have the potential to beaffected.</p> <p>2.What measures will be put into placeor what systemic changes will be made to ensure that thedeficient practice does not recur: a.Staff re-educated with regard tobest practices to ensure that they store, prepare, distribute, and serve foodunder sanitary conditions; to include proper hygiene, hair nets being worn atall times, and food to be covered when in the refrigerator. b.Staff will be re-educated on dishwashing temps to ensureproper temps throughout the entire cycle. c.Service man in to check dish machine concluding no repairsnecessary. d.A log will be kept to ensure proper temps are maintained.</p> <p>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what qualityassurance program will be put into place.</p> <p>1.Dietary manager and designee willobserve through rounds to assure compliance with hand hygiene and hairnetprotocols.</p> <p>2.Audits of temperature logs will becompleted by dietary manager and designee.</p> <p>3.Results of audit will be reported toQA monthly for total of six months. Ifdeficiencies are noted the Quality Assurance Committee will develop plans ofaction to correct and recommend continued monitoring</p>	

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	equipment." The above manual also indicated, "Hair Restraints, Number 1, ...Staff shall wear hair restraints in all food production, dishwashing and serving areas."		until corrections are effective. 4. Compliance of the plan by July 12, 2016.		