

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815
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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 1, 2, 3, 4, 5, 8, 9, & 10, 2015</p> <p>Facility number: 000282 Provider number: 155755 AIM number: 100287520</p> <p>Census bed type: SNF: 4 SNF/NF: 104 Residential: 41 Total: 149</p> <p>Census payor type: Medicare: 4 Medicaid: 67 Other: 78 Total: 149</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The creation and submission of this Plan of Correction is not an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The Plan of Correction is submitted because of requirements under the State or Federal law. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after July 10, 2015. Our documents for verification of compliance will be attached, or those referenced but not attached will be sent through Gateway or delivered to Kim Rhoades via USPS on or before July 10, 2015.</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 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>			

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a resident with a stage III pressure sore (Full thickness tissue loss) which had a documented increase in size and severity codes was reported to the physician or Nurse Practitioner (NP) for 1 of 3 residents reviewed for pressure sores. (Resident #6)</p> <p>Findings include:</p> <p>On 6/4/15 at 1:30 p.m., the clinical record of Resident #6 was reviewed. The resident was admitted to the facility on 1/9/15. The MDS (Minimum Data Set) assessment, dated 4/15/15 included but was not limited to, the following: moderate cognitive impairment, bed mobility, toilet use, personal hygiene and transfers required extensive assistance; indwelling urinary catheter, occasional incontinent of bowel; unhealed pressure sores, one assessed a stage 3, length 1.5 cm (centimeters), width 1.8 cm; slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous). Diagnoses included, but were not limited to, the following: chronic airway obstruction, asthma, malaise and fatigue, mild cognitive</p>	F 0157	<p>It is the practice of this provider to ensure that the resident's physician is notified when there is an increase in the size or severity of a pressure sore.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>Resident #6 was seen by Wound NP on 6/5/2015 and wound was assessed at that time.</p> <p>How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions will be taken</p> <p>All residents with pressure areas have the potential to be affected by the alleged deficient practice. All residents with pressure areas have been reviewed to ensure recent physician/NP notification of condition of wound is documented.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur</p> <p>Facility policy regarding wound assessment and documentation has been revised to ensure physician notification of any change in wound size, appearance, odor,</p>	07/10/2015

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	<p>impairment, cardiovascular disease, chronic kidney disease stage III, diabetes type 2; coronary artery disease, osteoarthritis, and leukocytosis.</p> <p>A Braden scale, dated 1/9/15 and 4/13/15, had a total score of 16. The form indicated a score of 16 or less, would be considered high risk for development of pressure ulcers.</p> <p>On 6/5/15 at 8:37 a.m., the DNS (Director of Nursing Services) provided a current copy of Resident #6's "Pressure Ulcer Monitoring Documentation Form." This form documented the initial date of the Stage 3 pressure sore (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) found on the "left sacrum" on 3/25/15, with an initial measurement of 1.6 cm (centimeter) length x 1.2 cm width and depth under 0.1 cm. Documentation was lacking in the nurse's notes of the physician or NP (Nurse Practitioner) being notified in relation to the resident's change in wound code from a wound code of 3 to a wound code of 4. On 5/8/15, a wound code was a 3 (slough) and the wound measured length 2 cm and width 2 cm. The wound code increased</p>		<p>exudate, occurs timely. Licensed nurses have been in-serviced on facility policy.</p> <p>How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>A QA assessment tool will be used 5 days a week x 2 months, then 3 days a week x 2 months, then once weekly x 2 months to monitor for physician notification when a pressure area changes by the DNS/Designee.</p> <p>Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p>	

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	<p>to a 4 (necrotic tissue) on 5/19 /15 and wound measurements were length 3 cm and width of 3.5 cm as documented on the "Pressure Ulcer monitoring documentation form." Documentation was lacking in the clinical record of the physician or NP being notified of the nurse's note on 5/31/15 at 1:44 p.m. of the "wound is deeper than when previously assessed and is starting to tunnel." Documentation was also lacking in the clinical record of the physician or NP being notified of the documented "tunneling" of the wound as documented on 6/3/15 on the "Pressure Ulcer monitoring documentation form"</p> <p>On 6/5/15 at 12:25 p.m., the DON provided a current copy of the plan of care which addressed the problem of "...potential for impaired skin integrity r/t impaired mobility ...and MASD (Moisture Associated Dermatitis) to coccyx, 3/25/15 stage III to sacrum." The goal date was 7/15/15 and approaches included but were not limited to, the following: "...staff to observe my skin for redness...open areas. Notify nurse for notification of MD/NP as needed..."</p> <p>On 6/8/15 at 10:24 a.m., the C.O. (Compliance Officer) provided a current copy of the undated policy and procedure for "Pressure Ulcers and Skin</p>			

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	<p>Breakdown." The policy included, but was not limited to, the following: "Policy: It is the policy of (name of facility) to assess, document and treat any and all skin related issues on a weekly basis...Monitoring...Pressure ulcers and skin breakdown is to be monitored and documented on Wound and Skin Assessment form by nursing staff weekly including location, measurements including presence of undermining or tunneling if applicable, drainage, pain, stage if pressure area...changes in wound characteristics...notify family or representative of any changes if applicable and current treatment."</p> <p>On 6/8/15 at 10:38 a.m., the C.O. (Compliance Officer) was interviewed. She indicated she was unable to find documentation of the physician having been notified of the documented change in the resident's wound on 5/19/15 of the "code" for "most severe type for any pressure ulcer." On 5/8/15, the code was documented as 3 (slough)/4 (eschar) with a size of 2 cm length x 2 cm width, unstageable. Documentation was lacking of an assessment completed on 5/15/15 and the next assessment on 5/19/15 indicated the code was a 4 and the size of the wound had increased to 3 cm length x 3.5 cm width. The C.O. was also unable to find documentation on 5/31/15 of the</p>			

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F 0309 SS=D Bldg. 00	<p>physician having been notified of the following nurse's note (NN): at 1:44 p.m.: "writer changed dressing to sacrum area...wound is deeper than when previously assessed and is starting to tunnel..."</p> <p>On 6/8/15 at 2:33 p.m., the Community C Nurse Leader was interviewed regarding the Nurse's note from 5/31/15 and the monitoring documentation from 6/3/15, which referenced the wound tunneling. She indicated she makes the wound rounds with the wound Nurse Practitioner. She indicated the resident had "an indentation" in the wound eschar but she did not observe any tunneling in this resident's wound.</p> <p>3.1-5(a)(3)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was provided adequate</p>	F 0309	It is the practice of this provider that each resident receive the necessary care and services to attain or maintain the highest	07/10/2015	

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	<p>accommodations to encourage successful, independent eating for 1 of 3 residents reviewed for positioning. (Resident #78)</p> <p>Findings include:</p> <p>On 6/3/15 at 11 a.m., the clinical record of Resident #78 was reviewed. Diagnoses included, but were not limited to, the following: Dementia with behavioral disturbances, osteoarthritis, scoliosis (sideway curve to the spine) and anxiety. The MDS (Minimum Data Set) assessment dated 4/28/15 included but was not limited to, the following: severe cognitive impairment; eating required limited assistance and functional ROM (range of motion) had no impairment to upper extremities, shoulder, elbow, wrist and hand. A physician order dated 1/27/15 indicated the following: "Admit to (name of Hospice) with primary dx (diagnosis) of protein calorie malnutrition..." A Functional Status form, dated 4/27/15, included but was not limited to, the following: Code for limitation that interfered with daily functions or placed at risk for injury: upper extremity (shoulder, elbow, wrist, hand) was documented as impairment on both sides.</p> <p>A Dietary note dated 4/27/15 at 9:43</p>		<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Resident #78 is provided with an adjustable table set to her needs. Hospice OT evaluated resident for adaptive equipment, and made recommendations. The resident has been provided with the adaptive equipment and is receiving increased staff encouragement to eat.</p> <p>How will you identify other residents having the potential to be affected by the alleged deficient practice and what corrective action will be taken All residents with postural or upper extremity limitations could be affected. OT will screen all residents to determine need for adaptive equipment. Residents not on Hospice will be followed up by the facility-contracted OT, and residents receiving hospice services will be referred to their hospice provider for follow up.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not</p>	

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	<p>a.m., included but was not limited to the following: "Is able to feed herself with up to limited assist in the dining room. Averages 85% bkfst (breakfast), 70% lunch and 55% supper consumed." A Dietary note dated 5/18/15 included but was not limited to, the following: "Monthly weight 84# (pounds), no sign (significant) weight change. She cont (continues) on mech (mechanical) soft diet with regular bacon. She receives power products with meals for additional calories. She continues to be followed by Hospice. Weight changes anticipated with terminal condition."</p> <p>A care plan, with a goal date of 7/28/15 addressed the following problem: "...at risk for weight changes and dehydration r/t (related to) variable intakes, dx (diagnosis) of dementia...goal to maintain weight above 81 pounds...Approaches: diet as ordered, power products with meals...monitor food consumption daily, monitor weights at least monthly..." A care plan, with a goal date of 7/28/15, addressed the problem of "...pain r/t arthritis and scoliosis..."</p> <p>On 6/1/15 at 11:18 a.m., the Birchwood dining room was observed. Resident #78 was observed sitting in her wheelchair (wc) at the table. The resident was observed to have a kyphotic</p>		<p>recur Residentsadmitted to the facility will be screened to determine the need for adaptiveequipment. OT will educate nursing staff on indicators for possible need of OTevaluation for adaptive eating equipment. Nursing staff will be responsible forongoing observations of residents and referral of residents with possible needfor adaptive equipment to OT staff. A facilitypolicy has been developed to define the process. Howthe corrective action(s) will be monitored to ensure the alleged deficient practice will notrecur, i.e., what quality assurance program will be put into place A QA assessment tool will beutilized once weekly x 4, once monthly x 5 by the DNS/designee to monitor theneed for adaptive eating equipment. Audit results will be reviewed by the QAcommittee and action plans developed to improve performance, which may includeeducation, skills validations, performance improvement, and/or disciplinaryaction. The need for on-going monitoring will be based upon compliance rates.</p>	

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	(exaggerated rounding of the back) posture and lean her head somewhat to the left shoulder. The level of the table was just below the resident's collar bone height and above her breast level. She was observed to have bowl of a dessert in front of her. The resident was observed to grasp the handle of the spoon between her right thumb and her extended index finger. The fingers on her right hand remained outstretched and did not fold around the handle of the spoon. Due to the elevated height of the table, the resident was observed to have to lift her spoon upward to get it out of the dish and then she would turn the spoon over, with the bowl of the spoon tilted on its side, facing the resident and downward. The resident was then observed to bring the spoon in a downward motion to reach her mouth, while some of the contents of the spoon were observed to fall out of the spoon and onto the resident's lap. Resident #78 was observed to have various pieces of the dessert in her lap. Caregiver #1 was observed to be assisting another resident while sitting across the table from Resident #78. At 11:21 a.m., Caregiver #1 was observing Resident #78 and asked Resident #78 "Is that good (name of resident)?" Resident #78 nodded "yes" and also indicated verbally she had dropped food on her pants. Caregiver #1 indicated " I'll get it."			

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	<p>Caregiver #1 continued to feed the resident across the table from Resident #78. The resident was observed to moan and the Caregiver #1 indicated "Are you ok (name of Resident #78)?" Resident #78 indicated again "I got it on my pants." Caregiver #1 again indicated "I'll get it." Caregiver #1 continued to feed the other resident across the table from Resident #78.</p> <p>On 6/3/15 at 11:19 a.m., Resident #78 was again observed in her wc in the dining room. Again, the level of Resident #78's chin was observed to be a few inches above the level of the table top. The resident was observed to lean her head towards her left shoulder, at times with her ear nearly resting on her left shoulder.</p> <p>The resident was observed to be holding the spoon in the manner observed on 6/1/15 at 11:18 a.m. As the resident would scrape food up from her plate with the spoon, she would tip the end of the spoon upwards and turn the bowl of the spoon in a vertical position. As she brought the utensil to her mouth, she was observed to not get food into her mouth. When Resident #78 took the spoon away from her mouth, there was food still observed on the bowl of the spoon. At 11:23 a.m., Caregiver #1 asked the Resident #78 "Do you need anything</p>			

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	<p>else?" Caregiver #1 was observed to provide the resident a piece of frosted red velvet cake. The cake was observed to be 2 inches high. Resident #78 indicated to Caregiver #1 the cake was "too big." Caregiver #1 indicated "It's too big, just a minute." Caregiver #1 then went to wash her hands and did not return to assist Resident #78. At 11:27 a.m., Caregiver #1 returned to the table and sat down at the table across from Resident #78, and assisted another resident. Caregiver #1 stated to Resident #78, "What's wrong with your cake, it's just too big, too much?" At this time, the resident's chin level was even with the top of the cake. The resident's response could not be heard. She was observed to use her spoon and she was able to pull a piece of cake off with her spoon. She then leaned inwards toward the table and pushed the cake in her mouth after dragging it across her plate with her spoon. The frosting did adhere to her spoon with cake attached. When the resident pulled the spoon away from her mouth, the piece of cake fell to her lap. The resident then picked the cake up from her lap with her fingers and put it into her mouth. At 11:34 a.m., Caregiver #2 was observed to sit down beside the resident at the table and he cut her cake up for her into smaller pieces. Caregiver #2 then sat beside another resident at Resident #78's</p>			

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	<p>table. Resident #78 then put the cake into her spoon and when she put the spoon up to her mouth, she turned it partially upside down.</p> <p>On 6/4/15 at 11:03 a.m., Resident #78 was observed in the Birchwood dining room. Again she was observed sitting in her wheelchair with the table height just below chin level. The plate was observed in front of the resident and to the left of her meal plate was a plate of a dessert item. The resident's head was again leaning towards her left shoulder. With the spoon in her right hand, the resident was observed to lunge at the food on the small dessert plate. The resident was observed to gather a bit of food in the spoon and then she turned the spoon upside down as she took it to her mouth. The dessert item was sticky so the food did stick to the spoon. At 11:10 a.m., Caregiver #1 sat down at the table between two residents across the table from Resident #78. Caregiver #1 then moved the resident's dessert plate in front of the resident. The resident was also observed to reach for her glass of water, which was on the resident's right side. When she reached for the glass, Resident #78 was able to place her right thumb and the tips of her right fingers on the glass. She was then observed to leave the bottom of the glass on the table and while</p>			
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	<p>leaning upward and in towards the table, tipped the glass to her lips. The resident continued with her head leaning towards her left shoulder. At 11:16 a.m., Caregiver #1 continued sitting at Resident #78's table. At 11:18 a.m., Resident #78 was attempting to finish her strawberry short cake, which was on a plate. She was observed to have her head nearly resting on her left shoulder. With the spoon, she drug the dessert off the plate and onto the table. She then leaned up to the table and pushed the food into her mouth with the spoon. When the resident reached toward the cup on the right side edge of the table, she moved her right shoulder up a bit to be able to grab the glass. She tipped the glass in the manner as described above to her mouth. As she tipped the glass towards her with the bottom resting on the table, she spilled the glass of water.</p> <p>On 6/5/15 at 11:06 a.m., the DNS (Director of Nursing Services) was made aware of Resident #78's difficulty eating and drinking at the table. The DNS indicated, "It looks like we need to get OT (Occupational Therapy) involved."</p> <p>On 6/8/15 at 10:33 a.m., the C.O. (Compliance Officer) was interviewed. She indicated she wasn't sure if the reason Resident #78 had not had her</p>			

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F 0314 SS=D Bldg. 00	<p>eating evaluated was because this resident was a Hospice resident. She indicated nursing staff were the ones who saw the resident most frequently. She indicated it had been at least 6 months since the resident had had an OT evaluation. The C.O. also indicated the Rehabilitation screen assessment, dated 1/15/15, indicated the resident didn't have any changes so the C.O. indicated this meant the resident didn't have any problems eating. The 1/15/15 OT Assessment included, but was not limited to, no identified concerns with positioning (wheelchair, bed) and/or eating.</p> <p>3.1-37(a)</p> <p>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. Based on observation, interview and record review, the facility failed to ensure</p>	F 0314	It is the practice of this provider to ensure, based on the comprehensive assessment, that	07/10/2015

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	<p>a resident with a stage III pressure sore was assessed weekly and accurately assessed for 1 of 3 stage III or IV pressure sores reviewed. The facility further failed to ensure the Physician or Nurse Practitioner were notified when the pressure sore increased in size. (Resident #6)</p> <p>Findings include:</p> <p>On 6/4/15 at 1:30 p.m., the clinical record of Resident #6 was reviewed. The resident was admitted to the facility on 1/9/15. Diagnoses included, but were not limited to, the following: chronic airway obstruction, asthma, malaise and fatigue, mild cognitive impairment, cardiovascular disease, chronic kidney disease stage III, diabetes type 2; coronary artery disease, osteoarthritis and leukocytosis. The admitting MDS (Minimum Data Set) assessment, dated 1/16/15, indicated the resident did not have any unhealed pressure ulcers at a stage 1 (redness) or higher. The MDS (Minimum Data Set) assessment, dated 4/15/15 included, but was not limited to, the following: moderate cognitive impairment, bed mobility, toilet use, personal hygiene and transfers required extensive assistance; indwelling urinary catheter, occasional incontinent of bowel; unhealed pressure sores, one at a stage 3</p>		<p>a resident who enters the facility without pressure sores doesnot develop pressure sores unless the individual's clinical conditiondemonstrates that they were unavoidable, and a resident having pressure soresreceives necessary treatment and services to promote healing, prevent infectionand prevent new sores from developing.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the alleged deficient practice Resident #6 is receivingweekly wound measurements and has been followed up by the Wound NP. Thephysician is notified accordingly. Howwill you identify other residents having the potential to be affected by the alleged deficient practice and whatcorrective action will be taken All residents with currentpressure ulcers or who are at risk for developing pressure ulcers have the potential to be affected. All pressure risk assessments have beenreviewed and updated as necessary. Allresidents with current wounds were reviewed and accurate weekly assessments arenow in place. Whatmeasures will be put into place or what systemic changes you will make toensure that the alleged</p>	

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	<p>(full thickness tissue loss. Subcutaneous fat may be visible; slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling), length 1.5 cm (centimeters), width 1.8 cm; slough.</p> <p>On 6/4/15 at 3:20 p.m., Resident #6's current open area to her left upper, inner buttock was observed. The unstageable area was observed to be in a square pattern, 1 and 1/2 inches square. The top of the unstageable pressure sore, was in horizontal line with the top of the resident's intergluteal cleft. The left side of the square unstageable pressure sore extended to the left side of the intergluteal cleft. The right side of the square unstageable pressure sore bordered the intergluteal cleft. The resident was observed to have a Foley catheter anchored at this time.</p> <p>A " Move-In Nursing History and Physical " dated 1/9/15 included, but was not limited to, the following: history of pressure ulcers and skin was observed intact.</p> <p>A Braden scale, dated 1/9/15 and 4/13/15, had a total score of 16. The form indicated a score of 16 or less and would be considered high risk for development of pressure ulcers. The</p>		<p>deficient practice does not recur</p> <p>Facility policy has been revised to ensure wounds are properly assessed and documentation is available.</p> <p>Licensed nurses were re-educated on completing and documenting pressure ulcer/wound assessments accurately and at least weekly in accordance with facility policy.</p> <p>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>A QA assessment tool will be utilized weekly x 4, monthly x 6 then quarterly thereafter, to monitor assessment of wounds by the DNS/Designee. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p>		

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	<p>assessment included, but was not limited to, the following information: sensory = 3 for slightly limited; moisture =4 rarely moist; activity=2 chair fast; mobility=2 very limited; nutrition=3 adequate; friction and shear=2 potential problem.</p> <p>On 6/5/15 at 8:37 a.m., the DNS (Director of Nursing Services) was interviewed and provided a current copy of Resident #6's "Pressure Ulcer Monitoring Documentation Form." The DNS indicated this documentation pertained to the current pressure sore, which was observed on 6/4/15 at 3:20 p.m. This form documented the initial date of the Stage 3 pressure sore found on the "left sacrum" on 3/25/15, with an initial measurement of 1.6 cm (centimeter) length x 1.2 cm width and depth under 0.1 cm. The form also indicated the Stage 3 pressure ulcer developed after admission to the facility. The form indicated assessments were completed on the following dates: 3/25/15; (4/1/15 was a monthly nursing summary assessment); 4/9/15; documentation was lacking of an assessment on 4/16/15; weekly skin assessments continued on 4/21/15; 4/24/15; documentation was lacking of an assessment on 5/1/15; skin assessments continued on 5/8/15; 5/13/15 was a monthly nursing summary;</p>			

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	<p>5/19/15; 5/22/15; documentation was lacking of an assessment being done on 5/29/15; skin assessments continued on 6/3/15 and 6/5/15.</p> <p>Nurse's notes dated 5/8/15 at 8:05 a.m., included but were not limited to the following: "...Resident seen by wound nurse...for eval (evaluation) of areas to coccyx, left sacrum and left Ischial. Coccyx and Ischial are closed..."</p> <p>Documentation was lacking in the nurses notes on 5/19/15, in relation to the resident's change in wound code (Most severe tissue type for any pressure ulcer codes) from a 3 (slough) to a 4 (necrotic tissue/eschar) and/or increase in size of the wound as had been documented on the Pressure Ulcer Monitoring Documentation form on 5/19/15.</p> <p>Documentation was also lacking in the nurses notes on 5/19/15 of nurse practitioner and/or physician notification of the wound changes.</p> <p>A "Wound Assessment Form" dated 5/22/15 and completed by the wound Nurse Practitioner, included, but was not limited to, the following: "Sacral Pr (pressure) ulcer, increased necrotic tissue, debrided and changed tx (treatment)..."</p> <p>A nurse note, dated 5/31/15 at 1:11:44</p>			

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	<p>p.m. included, but was not limited to, the following: " ...dressing to sacrum ...Wound is deeper than when previously assessed and is starting to tunnel ... "</p> <p>A 6/3/15 entry on the " Pressure Ulcer Monitoring Documentation Form " included, but was not limited to, the following: " ...Tunneling ...yes ... " This entry was the first documented date of " tunneling " on this form. Documentation was lacking of a thorough assessment of the " tunneling. "</p> <p>On 6/5/15 at 10:20 a.m., the DNS was interviewed. She indicated skin assessments were done monthly per nursing on all residents and weekly skin assessments were done on residents with identified open areas. She indicated the wound nurse practitioner (NP) saw the resident on the following dates: 3/25/15, 4/9/15, 4/24/15, 5/8/15, 5/22/15 and 6/5/15. The DNS indicated the monthly nursing skin assessments were completed on the following dates: 4/1/15, 5/13/15 and 6/3/15.</p> <p>The wound Assessment form, completed by the wound nurse practitioner on 6/5/15, included but was not limited to, the following: location of wound "L (left) sacrum; pressure, unstageable, length 4 cm; width 3.7 cm and depth</p>			

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	<p>unable to determine. The Wound NP did not reference any tunneling in the wound in her assessment.</p> <p>On 6/5/15 at 12:25 p.m., the DNS provided a current copy of the plan of care, undated, which addressed the problem of "...potential for impaired skin integrity r/t (related to) impaired mobility, frequent incont (incontinence), and MASD (moisture associated dermatitis) to coccyx. Approaches included, but were not limited to, the following: 2/23/25 Anchor catheter; 1/16/15, assist me to turn and reposition approximately every 2 hours as needed; 1/16/15, observe my skin for redness, excoriation, open areas; 1/16/15, Notify nurse for notification of MD/NP as needed; 1/16/15, "...pressure relieving mattress to my bed...pressure relieving cushion to...wheelchair..."</p> <p>On 6/5/15 at 12:25 p.m., the DNS provided a current copy of the additional plan of care which addressed the problem of "...potential for impaired skin integrity r/t impaired mobility, incont, MASD to coccyx and 3/25/15 stage III to sacrum." The goal date was 7/15/15 and approaches included but were not limited to, the following: "...staff to observe my skin for redness...open areas...notify nurse for notification of MD/NP as</p>			

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	<p>needed..."</p> <p>On 6/8/15 at 10:24 a.m., the C.O. (Compliance Officer) provided a current copy of the undated policy and procedure for "Pressure Ulcers and Skin Breakdown." The policy included, but was not limited to, the following: "...Policy: It is the policy of (name of facility) to assess, document and treat any and all skin related issues on a weekly basis...Monitoring...Pressure ulcers and skin breakdown is to be monitored and documented on Wound and Skin Assessment form by nursing staff weekly including location, measurements including presence of undermining or tunneling if applicable, drainage, pain, stage if pressure area...changes in wound characteristics...notify family or representative of any changes if applicable and current treatment...."</p> <p>On 6/8/15 at 10:38 a.m., the C.O. (Compliance Officer) was interviewed. She indicated the residents with currently identified pressure areas were assessed weekly, every 7 days. At 10:45 a.m., she indicated all the weekly skin assessments are kept on the Pressure ulcer monitoring documentation form. At this time, the C.O. indicated the following: she was unable to locate documentation of weekly skin assessments having been completed</p>			

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	<p>on 4/16/15, 5/1/15 and 5/29/15. She indicated she was also unable to find documentation of the physician having been notified of the documented change in the resident's wound on 5/19/15 of the "code" for "most severe type for any pressure ulcer." On 5/8/15, the code was documented as 3/4 slough/necrotic tissue with a size of 2 cm length x 2 cm width, unstageable. Documentation was lacking of an assessment completed on 5/15/15 and the next assessment on 5/19/15 indicated the code was a 4 and the size of the wound had increased to 3 cm length x 3.5 cm width. The treatment was changed on 5/22/15 and the wound measured 3.5 cm length x 3.4 cm width, unstageable. The C.O. was unable to find documentation on 5/31/15 of the physician having been notified of the following nurses note (NN): at 11:44 p.m.: "writer changed dressing to sacrum area...wound is deeper than when previously assessed and is starting to tunnel..." The C.O. was also unable to find documentation of an assessment which pertained to the 6/3/15 entry of the left sacral wound documented as having had tunneling. The 6/3/15 entry was the first reference on the Pressure Ulcer monitoring documentation form of the wound having had tunneling. She also indicated the documentation of the "tunneling" was incomplete in regards to</p>			

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F 0315 SS=D Bldg. 00	<p>the location and/or extent of the "tunneling."</p> <p>On 6/8/15 at 2:33 p.m., the Community C Nurse Leader was interviewed regarding the Nurse's note from 5/31/15 and the monitoring documentation from 6/3/15, which referenced the wound tunneling. She indicated she makes the wound rounds with the wound Nurse Practitioner. She indicated the resident had "an indentation" in the wound eschar but she did not observe any tunneling in this resident's wound.</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure the urinary catheter care policy for positioning of the urinary drain tube off</p>	F 0315	It is the practice of this provider to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's	07/10/2015

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	<p>the floor was followed for 1 of 3 residents reviewed for urinary catheters. (Resident #2)</p> <p>Findings include:</p> <p>An observation on 6-1-2015 at 2:15 p.m., indicated Resident #2 was in her room and in her wheelchair with the urinary drain tubing on the floor under her wheelchair.</p> <p>An observation on 6-2-2015 at 11:05 a.m., indicated Resident #2 was in her wheelchair in the dining room with the urinary drain tubing on the floor under her wheelchair. An observation at 11:47 a.m., indicated the urinary drain tubing was still on the floor.</p> <p>An observation on 6-2-2015 at 1:20 p.m., indicated Resident #2 was in her room in her wheelchair with the urinary drain tubing on the floor under her wheelchair.</p> <p>An observation on 6-2-2015 at 3:58 p.m., indicated Resident #2 was in her room in her wheelchair with the urinary drain tubing on the floor under her wheelchair.</p> <p>An observation on 6-3-2015 at 4:30 p.m., indicated Resident #2 was in the dining room in her wheelchair with the urinary drain tubing on the floor under</p>		<p>clinicalcondition demonstrates that is was necessary and a resident who is incontinentof bladder receives appropriate treatment and services to prevent urinary tractinfection and to restore as much bladder function as possible.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the alleged deficient practice Resident #2's catheter hasbeen repositioned to avoid catheter tubing lying on the floor.</p> <p>Howwill you identify other residents having the potential to be affected by the allegeddeficient practice and what corrective action will be taken Residentswith catheters have the potential to be affected by the alleged deficientpractice. All current residentswith catheters have been reviewed and are being monitored for proper placementof catheter tubing.</p> <p>Whatmeasures will be put into place or what systemic changes you will make toensure that the alleged deficient practice does not recur Facility policy regardingcatheter care has been reviewed and revised to ensure appropriate care isrendered. Nursingstaff has been</p>	

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	<p>her wheelchair.</p> <p>An observation on 6-4-2015 at 8:55 a.m., indicated Resident #2 was in the dining room in her wheelchair with the urinary drain tubing on the floor under her wheelchair while the activity person was applying lotion to the Resident's hands.</p> <p>An observation on 6-4-2015 at 11:09 a.m., indicated Resident #2 was in the dining room in her wheelchair with the urinary drain tubing on the floor under her wheelchair.</p> <p>An observation on 6-4-2015 at 1:10 p.m., indicated Resident #2 was in her room in her wheelchair with the urinary drain tubing on the floor under her wheelchair.</p> <p>An observation on 6-5-2015 at 9:33 a.m., indicated Resident #2 was in the dining room in her wheelchair with the urinary drain tubing on the floor under her wheelchair.</p> <p>An interview with Caregiver #10 on 6-5-2015 at 9:35 a.m., indicated for a resident with a Foley catheter, the drain tubing should have been kept up off the floor.</p> <p>An interview with LPN (Licensed Practical Nurse) #12 on 6-5-2015 at 9:40</p>		<p>re-educated on catheter care which included positioning ofcatheter tubing by theDNS/designee.</p> <p>Howthe corrective action(s) will be monitored to ensure the alleged deficientpractice will not recur, i.e., what quality assurance program will be put into place</p> <p>A Catheter QA tool will beutilized daily for 4 weeks, weekly x 4, monthly x 2, and quarterly x 2 to monitorcompliance with indwelling catheters. Audit results will be reviewed by the QAcommittee and action plans developed to improve performance, which may includeeducation, skills validations, performance improvement, and/or disciplinaryaction. The need for on-going monitoring will be based upon compliance rates.</p>	

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	<p>a.m., indicated the Foley catheter drain tubing under Resident #2's wheelchair should not have been on the floor.</p> <p>The record review for Resident #2 began on 6-5-2015 at 11:39 a.m. The physician's orders for 4-30-2015 were signed by the physician on 5-12-2015. Diagnoses included but were not limited to hypothyroidism, glaucoma, osteoarthritis, incomplete bladder emptying, iron deficiency anemia, hypertension and osteoporosis.</p> <p>Physician orders indicated a start date of 9-14-2012, for the following, "...catheter orders Foley catheter to straight drain...."</p> <p>Physician orders indicated a start date of 2-12-2015, for the following, "...Foley cath (catheter) orders change #18 Foley cath every three weeks on evening shift...."</p> <p>Physician orders indicated a start date of 12-6-2012, for the following, "...Alternate sides where cath tubing lays may use paper tape if needed...."</p> <p>A review of the Quarterly MDS (Minimum Data Set) assessment dated 3-10-2015, indicated Resident #2 required maximum assistance of one person for transfers, toileting and personal care.</p>			

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F 0323 SS=E Bldg. 00	<p>A review of the current Caregiver Assignment Sheet provided by the DNS (Director of Nursing Services) on 6-4-2015 at 3 p.m., indicated the Resident #2 required "assist x 1, gait belt and wheelchair..." for mobility transfer status and "...1 assist..." for toileting.</p> <p>An current policy "Urinary Catheter Care" which was undated and provided by the DNS (Director of Nursing Services) on 6-5-2015 at 10:10 a.m., indicated "...to establish guidelines to reduce the risk of, or prevent infections in the resident with an indwelling catheter...urinary drainage bags and tubing shall be positioned to prevent either from touching the floor...."</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure cleaning chemicals and personal care products were secured and out of reach of 38 ambulatory and confused residents of</p>	F 0323	It is the practice of thisprovider to ensure the resident's environment remains as free of accidenthazards as is possible; and each resident receives adequate supervision	07/10/2015

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	<p>104 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During the initial tour of the facility on 6-1-2015 from 9:25 a.m. -10:00 a.m., the following observations were made of an unlocked and unattended Spa room in Magnolia Manor: A cabinet with a lock on it, which was not secured, had an 11 ounce can of shave cream with a "...Keep out of Reach..." statement on the back of the can. A spray bottle with "50%/50 Vinegar/H2O (water)" on the label and with the instructions to "...rinse out urostomy bag...." was out on the counter. A partially used 12.5 ounce container of moisturizing shampoo was on the spa tub ledge with "...avoid contact with eyes...can cause eye irritation...in case of contact with eyes flush thoroughly with water..." on the label. A 32 ounce partially used spray bottle of ready to use multi purpose stain remover was on the spa tub ledge with "...Keep out of reach of children...avoid contact with skin, eyes and clothing...wash thoroughly after handling...." on the label.</p> <p>An observation of the unlocked and unattended Spa room in Magnolia Manor on 6-2-2015 at 9:40 a.m., indicated a</p>		<p>and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Personal care products in all affected resident rooms and spa areas have been moved so they are not accessible by wandering and confused residents. Chemicals used in the spa areas are secured in the locked cabinet when the room is not in use. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken All residents could be affected. All resident bathrooms have been inspected to ensure that potentially hazardous personal items are not easily accessible. All spa rooms throughout the facility have been inspected to ensure that chemicals are secured in the locked cabinet when the room is not in use. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur Facility policies addressing resident safety have been</p>	

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	<p>cabinet with a lock on it was not locked and contained a can of shaving cream on the shelf. A spray bottle with "50%/50 Vinegar/H2O" was out on the counter. A partially used 12.5 ounce container of moisturizing shampoo and a 32 ounce partially used spray bottle of ready to use multi purpose stain remover were observed on the spa tub ledge.</p> <p>An observation of the unlocked and unattended Spa room in Magnolia Manor on 6-3-2015 at 10:52 a.m., indicated a cabinet with a lock on it that was not locked and contained a can of shaving cream on the shelf. A spray bottle with "50%/50 Vinegar/H2O" was out on the counter. A partially used 12.5 ounce container of moisturizing shampoo and a 32 ounce partially used spray bottle of ready to use multi purpose stain remover were observed on the spa tub ledge.</p> <p>An observation of the unlocked and unattended Spa room in Magnolia Manor on 6-5-2015 at 2:10 p.m., indicated a cabinet with a lock on it that was not locked and contained a can of shaving cream on the shelf. A spray bottle with "50%/50 Vinegar/H2O" was out on the counter. A partially used 12.5 ounce container of moisturizing shampoo and a 32 ounce partially used spray bottle of ready to use multi purpose stain remover</p>		<p>reviewed to ensure procedures regarding security of potentially hazardous products are in place. Housekeeping and nursing staff have been in-serviced on applicable policies. They were made aware of their responsibility to immediately secure any accessible potentially hazardous item if possible, or report it to a supervisor.</p> <p>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>A QA assessment tool will be utilized weekly x 4, every other week x 2, monthly x 4, and quarterly thereafter, to monitor compliance. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p>	

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	<p>were observed on the spa tub ledge.</p> <p>2. An observation of an unlocked and unattended Spa room on the Birchwood Hills on 6-2-2015 at 11:00 a.m., indicated a cabinet with a lock, which was not secured and contained the following: A 1.5 ounce antiperspirant with "keep out of reach of children" on the label. Five 8 ounce bottles of caring body lotion partially used, with "keep out of reach of children" on the labels. An 8 ounce bottle of perineal wash. Cocoa Butter hand and body lotion 32 ounce size partially used. On the counter was a 1.5 ounce container of roll on anti perspirant and an 8 ounce bottle of shampoo and body wash.</p> <p>3. An observation of the Red Bud Trail unlocked and unattended spa room on 6-2-2015 at 11:11 a.m., indicated a body wash/shampoo bottle was on the spa tub ledge.</p> <p>An observation of the Red Bud Trail unlocked and unattended spa room on 6-3-2015 at 11:00 a.m., indicated a body wash/shampoo bottle was on the spa tub ledge.</p> <p>An observation of the Red Bud Trail unlocked and unattended spa room on 6-5-2015 at 11:11 a.m., indicated a body</p>			

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	<p>wash/shampoo bottle was on the spa tub ledge on its side and leaking.</p> <p>4. An observation of the Oak Drive Spa room on 6-2-2015 at 11:50 a.m., indicated the spa room was unlocked and unattended. Inside the spa was a cabinet with a lock, and the lock was not secured and contained the following: an 8 ounce bottle of perineal wash, two containers of 1.5 ounce roll-on antiperspirant and an 8 ounce bottle of shampoo/body wash.</p> <p>An interview with the DNS (Director of Nursing Services) on 6-5-2015 at 2:30 p.m., indicated the personal care products should be locked in the cabinet and chemicals should be secured and out of reach of residents.</p> <p>A list of ambulatory and confused residents by unit was provided by the Corporate Compliance Officer on 6-8-2015 at 8:00 a.m. and indicated 38 of the 104 residents who resided in the facility were confused and ambulatory in 8 of the 9 units.</p> <p>5. An observation of the Birchwood Hills nursing office in Unit C on 6-8-2015 at 11:05 a.m., indicated the door was open, the room was dark and unattended. A container of bleach wipes and a 60 ounce container of foaming</p>			

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	<p>hand sanitizer and lotion were out on top of the 4 drawer tall file cabinet. The labels on both the bleach wipes and the foaming hand sanitizer and lotion indicated to "keep out of reach of children...."</p> <p>An interview with Community Nurse Leader #11 on 6-8-2015 at 11:22 a.m., indicated the nursing offices on each unit should be locked when unattended.</p> <p>An interview with the Corporate Compliance Nurse on 6-8-2015 at 11:45 a.m., indicated the nursing offices should be kept locked when unattended.</p> <p>6. On the initial tour of the facility on 6/1/15 at 9:30 a.m., on the Oak Drive Unit, an unlocked spa room was observed. The unlocked cabinet observed in the spa room contained the following items: Medline Shampoo and Body wash and 2 bottles of Medline Antiperspirant and one bottle of Periwash.</p> <p>On 6/1/15 at 9:35 a.m., Birchwood Hills Unit was observed. The following was observed: On the wall by the sink, was an unlocked cabinet with the following items inside: 5 bottles of Medline lotion and Perispray (external use only). The following items were also observed</p>			

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	<p>inside the unlocked cabinet and had the information "keep out of reach of children" printed on the bottle; 32 oz (ounce) bottle of Hand and Body lotion, Medspa antiperspirant and a bottle of Mouthwash. A bottle of Medline shampoo was observed sitting on the top edge of the spa tub. Observed on the counter top by the sink was a bottle of MedSpa antiperspirant.</p> <p>On 6/1/15 at 10 a.m., Chestnut Place, a locked dementia unit, was observed. In the unlocked spa room, the following was observed: the cabinet, positioned on the wall beside the sink, had a keyed lock flush on the surface of the door panel. The door was able to be opened freely without the use of a key. Inside the cabinet, the following was observed: 3 bottles of Body Wash Shampoo, 8 oz each; 2 cans of Medspa Shaving cream, 11 oz each; a bottle of body lotion and a 15 oz (ounce) bottle of Vo5 Shampoo. The bottle of Vo5 shampoo was observed to have "Keep out of Reach of Children (KOROC)" on the label. Also observed was a bottle of "Mastercare Disinfectant."</p> <p>On 6/3/15 at 10:50 a.m., the Birchwood Hills spa room was observed. The items observed on 6/1/15 at 9:35 a.m. remained in the unlocked cabinet in the unlocked spa room. The Medline Shampoo and</p>			

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	<p>Body wash and Medspa Antiperspirant also remained on the counter. The items observed on 6/1/15 at 9:30 a.m. in the Oak spa room also had the personal care products which remained unsecured.</p> <p>On 6/3/15 at 11 a.m., the Chestnut Hills spa, was again observed. The unlocked items remained as observed on 6/1/15 at 10 a.m.</p> <p>On 6/5/15 at 2:10 p.m. the ADM (Administrator) and DNS (Director of Nursing Services) were made aware of the unsecured items in the unlocked spas on the A and C units on Birchwood Hills, Oak Drive and Chestnut Place units. The DNS indicated the personal care products and the disinfectant should not be left out unlocked.</p> <p>7. During observation of the Residents ' rooms on Maple Cove, a secured memory unit, the following was observed:</p> <p>On 6/1/15 at 2:19 p.m., room B8's bathroom had accessible personal care products within a resident's reach on the second open shelf beside the shower and included the following products: two, 8 oz. (ounce) bottles of Body Lotion, three 1.5 oz. bottles of Roll on Antiperspirant, two 4 oz. tubes of Remedy Nutrashield (a moisture barrier), one 8 oz. bottle of</p>			

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	<p>Perineal Wash, one 11 oz. can of Shave Cream and two 8 oz bottles of Shampoo and Body Wash.</p> <p>On 6/2/15 at 11:55 a.m., Room B3's bathroom had accessible personal care products within a resident's reach. On the countertop by the sink, there was a 7.5 oz bottle of Raspberry and Vanilla Hand Soap, which was labeled, "...Keep out of reach of children ..." and one 8 oz. bottle of Toasted Sugar Fragrance Mist which was labeled, "...External use only "</p> <p>On 6/2/15 at 11:55 a.m., an interview with Resident #12 who resided on Maple Cove, and was not identified as confused by the facility, indicated there were several residents who wandered in the hallways and in and out of her room during the day and night. She indicated one wandering resident would come in her room and open her dresser drawers and had taken some of her belongings.</p> <p>8. During observation of resident rooms on Hickory Ridge, a secured memory unit the following was observed: On 6/2/15 at 2:35 p.m., room B14's bathroom had accessible personal care products within a resident's reach on the second open shelf beside the shower and</p>			

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	<p>included the following products: one 8 oz. spray bottle of Peri Wash, one 8 oz. bottle of Shampoo and Body Wash, and two 8 oz bottles of Moisture Body Lotion.</p> <p>On 6/2/15 at 2:49 p.m., room B21's bathroom had accessible personal care products within a resident's reach on the top of the toilet and included the following products: one 8 oz spray bottle of Peri Wash and one 4 oz. tube of Remedy Nutrishield. The following personal care products were on the third open shelf beside the shower and accessible to residents and included the following products: one 8 oz. of bottle of Shampoo and Body Wash, one 4 oz tube of Remedy Nutrashield and one 10.1 oz bottle of [Brand] Shampoo, one 1.5 oz roll on antiperspirant, and one 8.45 oz [Brand] non-aerosol hair spray.</p> <p>On 6/2/15 at 3:30 p.m., room B25's bathroom had accessible personal care products within a resident's reach on the second open shelf by the shower and included the following products: two 8 oz. spray bottles of Peri Wash, one 8 oz bottle of Shampoo and Body Wash and one 8 oz. bottle of Body Lotion.</p>			

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	<p>On 6/3/15 at 1:33 p.m., room B17's bathroom had accessible personal care products within a resident's reach on the vanity sink top and included the following: one can of Shaving Cream, one 4 oz tube of Remedy Phytoplex Z-Guard (skin protectant). The following personal care products were on the third open shelf beside the shower and accessible to residents and included the following products: one 8 oz. spray bottle of Peri Wash, one 8 oz bottle of Shampoo and Body Wash, one 8 oz. bottle of Body Lotion, one 8 oz. bottle of All-In-One Perineal Lotion With Odor Control (skin protectant) and two 1.5 oz bottles of Roll on Antiperspirant.</p> <p>An interview on 6/3/15 at 1:33 p.m., with Resident #93, who was not identified as confused and independently mobile by the facility, indicated there were other residents who wander into his room. He further indicated the wandering residents picked up his belongings and those residents did not know what they were doing and he asked them to leave his room.</p> <p>An interview on 6/5/14 at 2:15 p.m. with CNL (Community Neighbor Leader) #18</p>			

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	<p>indicated the residents personal care products in the resident's bathrooms were within the reach of the wandering residents. She also indicated the personal care products should not be left out in the bathrooms. She further indicated the staff does a good job of keeping track of the residents but were not always able to watch all of the residents at all times when the staff provided care for another resident.</p> <p>9. Observation of the unlocked and unattended Spa on Maple Cove, a secured memory unit the following was observed:</p> <p>On 6/1/15 at 2:27 p.m. the Maple Cove Spa door was unlocked and had accessible personal care and cleaning products within a resident's reach and included the following: one 8 oz. bottle of Shampoo and Body Wash was on the corner of the whirlpool tub. There was also an unlocked door on the cabinet on the wall by the sink and included the following products: one 1.5 oz roll on antiperspirant on the 1st shelf of the cabinet and one 19 oz. aerosol can of Furniture Polish on the 2nd shelf of the cabinet.</p>			

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	<p>On 6/2/15 at 11:14 a.m., The Maple Cove Spa door was unlocked and had accessible personal care and cleaning products within a resident's reach as observed on 6/1/15 at 2:27 p.m.</p> <p>On 6/4/15 at 10:00 a.m., The Maple Cove Spa door was unlocked and had accessible personal care and cleaning products within a resident's reach as observed on 6/2/15 at 11:14 a.m.</p> <p>On 6/5/15 at 10:05 a.m., The Maple Cove Spa door was unlocked and had accessible personal care and cleaning products were within a resident's reach and included the following: There was also an unlocked door on the cabinet on the wall by the sink which included the following products: one 1.5 oz roll on antiperspirant on the 1st shelf of the cabinet and one 19 oz. aerosol can of Furniture Polish on the 2nd shelf of the cabinet.</p> <p>10. During an observation of the unlocked and unattended Spa on Hickory Ridge, a secured memory unit the following was observed:</p> <p>On 6/2/15 at 11:45 a.m., the Hickory Ridge Spa door was unlocked and had accessible personal care and cleaning</p>			

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	<p>products within a resident's reach which included the following: one 8 oz. bottle of Shampoo and Body Wash was turned upside down on the corner of the whirlpool tub. There was also an unlocked door on the cabinet on the wall by the sink and included the following products: one 8 oz. bottle of Shampoo and Body Wash, two 8 oz. spray bottles of Peri Wash, one 1.5 oz Roll on Antiperspirant.</p> <p>On 6/4/15 at 10:05 a.m., the Hickory Ridge Spa door was unlocked and had accessible personal care and cleaning products within a resident's reach and as observed on 6/2/15 at 11:45 a.m.</p> <p>On 6/5/15 at 10:00 a.m., the Hickory Ridge Spa door was unlocked and had accessible personal care and cleaning products within a resident's reach as observed on 6/2/15 at 11:45 a.m.</p> <p>An interview on 6/5/15 at 10:05 a.m. with Caregiver #27, indicated there were several residents who wander in and out of the residents' rooms on Maple Cove. She indicated the residents could not be watched every minute of the day. She indicated the Spa door was not locked and indicated the cabinet above the sink</p>			

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	<p>has a lock on it but she has never tried to open the cabinet door.</p> <p>An interview on 6/5/15 at 10:10 a.m. with LPN #19 indicated the cabinet in the Spas should be locked. During the observation of the unlocked cabinet in the Maple Cove Spa, she further indicated the furniture polish should not have been stored in the cabinet in the spa.</p> <p>Label information and Material Safety Data Sheets were provided for the personal care products and chemicals on 6-8-2015 at 1:30 p.m. by the Corporate Compliance Nurse and indicated the following:</p> <p>No information for the spray bottle with "50%/50 Vinegar/H2O" was provided as the Corporate Compliance Nurse indicated the bottle had been discarded.</p> <p>"...shavecream...11 ounce...keep out of reach of children...."</p> <p>"...roll-on anti-perspirant...1.5 fl (fluid) oz (ounces)...keep out of reach of children...."</p> <p>"...body lotion...8 fl (fluid) oz...for external use only...keep out of reach of children...."</p> <p>"...moisturizing shampoo...avoid contact with eyes...can cause eye irritation...in case of contact with eyes flush thoroughly with water...."</p> <p>"...perineal wash...8 fl oz...caution...for</p>			

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	<p>external use only...."</p> <p>"...remedy nutrashield 4 fl oz...warnings...for external use only...keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>"...shampoo & body wash 8 Fl Oz...caution...for external use only...avoid contact with eyes...."</p> <p>"...cocoa butter hand and body lotion 32 oz...for external use only...keep out of reach of children...."</p> <p>"...All-In-One Perineal Lotion with Odor Control...8 FL. OZ...warnings...when using this product avoid contact with eyes...for external use only...keep this and all drugs out of the reach of children...if swallowed, get medical help or contact a Poison Control Center right away..."</p> <p>Generic brand of "...black raspberry & vanilla hand soap...7.5 FL OZ...warnings...for external use only...hands only...avoid contact with eyes...if contact occurs, rinse thoroughly with water...keep out of reach of children...."</p> <p>"...toasted sugar fragrance mist...8 FL OZ...warning...flammable...keep away from flame or high heat...for external use only...."</p> <p>"...lemon oil furniture polish...19 Oz...caution...use with adequate ventilation...contact with skin or eyes may cause temporary irritation...flush</p>			

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	<p>eyes with water for a minimum of 15 minutes...keep out of reach of children...."</p> <p>"...Ready-to-Use Multi-Purpose Stain Remover...32 FL OZ...caution...causes eye irritation...first aid eyes and skin...immediately flush with plenty of water...keep out of reach of children...MSDS...undated...handling and storage...use in well-ventilated areas...avoid breathing vapors or mists, avoid ingestion and contact with eyes...do not taste or swallow...."</p> <p>"...Hospital Cleaner disinfectant towels with bleach...keep out of reach of children...avoid contact with eyes or clothing...wash thoroughly with soap and water after handling...MSDS dated January 5, 2015...first aid measures...ingestion...drink a glassful of water...call a doctor or poison control center...."</p> <p>"...foaming sanitizer & lotion 60 FL OZ...warnings...do not use in eyes, ears or mouth...in case of eye contact, flush with water immediately...keep out of reach of children...."</p> <p>"...one-step disinfectant cleaner...keep out of reach of children...DANGER...corrosive...causes irreversible eye damage and skin burns...do not get in eyes, on skin or on clothing...wear goggles or face shield, rubber gloves, and protective</p>			

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	<p>clothing...harmful if swallowed...if swallowed call poison control center or doctor immediately for treatment advice...if inhaled, move person to fresh air...if person is not breathing, call 911 or an ambulance then give artificial respiration...."</p> <p>A current facility "Personal Care Items" policy dated April 2010 and provided by the Corporate Compliance Officer on 6-8-2015 at 10:25 a.m., indicated "...residents personal care items will be maintained in a way to protect against cross contamination...procedure...</p> <ol style="list-style-type: none"> 1. Resident's personal care items will be kept in the individual apartments.... 2. All grooming supplies will be maintained in the bathroom, on the shelf in an orderly manner... 4. Supplies in the Secure Care areas will be maintained on the top shelf in the bathroom of the resident's apartment. 5. All supplies should be placed out of residents' reach when not in use. 6. Supplies in the Spa room will be maintained in a locked cabinet. 7. Cabinet to be locked at all times when staff not present to prevent resident access to chemicals and supplies." <p>3.1-45(a)(1)</p> 			

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F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility staff failed to wash their hands for the recommended amount of time and after touching a resident or a soiled object in 5 of 8 dining rooms. The facility also failed to ensure only food and beverages were kept in the freezer section of the refrigerator in 1 of 8 neighborhood pantries. The facility further failed to ensure food and beverages kept in the pantry freezer/refrigerator in 5 of 8 neighborhoods were properly sealed, labeled, and dated. This deficient practice had the potential to affect 104 of 104 residents who received food and beverages prepared, served, and stored by the facility kitchens.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the Birchwood dining room, the following was observed:</p>	F 0371	<p>F371 Food Procure, Store/Prepare/Serve - Sanitary</p> <p>It is the practice of this provider to procure, store, prepare distribute and serve food under sanitary conditions.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>Staff re-education on proper hand washing before/after having direct physical contact with residents or contact with potentially contaminated surfaces was initiated immediately upon survey exit. Refrigerators in all cited pantries were thoroughly inspected and all undated, unlabeled food and beverages and non-food items were removed.</p> <p>How will you identify other residents having the potential</p>	07/10/2015
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	<p>At 11:10 a.m., Caregiver #1 was observed to lather her hands for 10 seconds prior to rinsing. She was then observed to continue assisting with meal service.</p> <p>At 11:21 a.m., Caregiver #2 was observed to lather his hands for 10 seconds prior to rinsing. He was then observed to continue assisting with meal service.</p> <p>2. During an observation of the lunch meal in the Hickory Ridge dining room, the following was observed:</p> <p>At 11:34 a.m., Caregiver #3 was observed to assist a resident into a dining room chair, touching the back of the dining room chair, the resident, and his walker. She was not observed to wash her hands after touching the soiled items.</p> <p>At 11:37 a.m., Caregiver #4 was observed to enter the dining room. She was observed to lather her hands for 6 seconds prior to rinsing. She was then observed to assist with meal service.</p> <p>At 11:38 a.m., Caregiver #3 was observed to pick up the eating utensils from a resident's tray to assist him in cutting his food into smaller pieces. She was then observed to leave the dining</p>		<p>to be affected by the alleged deficient practice and what corrective action will be taken</p> <p>All residents who reside in the facility have the potential to be affected. Staff re-education on proper hand washing before/after having direct physical contact with residents or contact with potentially contaminated surfaces was initiated immediately upon survey exit. Refrigerators in all cited pantries were thoroughly inspected and all undated, unlabeled food and beverages were removed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</p> <p>All staff is educated and completes skills validations to ensure competency with hand washing upon hire and through the facility-wide in-service education program no less than twice a year. Nursing staff is also educated on proper storage, sealing, dating and labeling of food and beverage items stored in freezers/refrigerators during initial orientation to their assigned work duties. Nursing and dietary staff received re-education on proper hand washing before/after having direct physical contact with residents or after contact with a</p>	

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	<p>room and enter a resident's room across the hall. She was observed to obtain a pair of disposable gloves and place them on her hands to pick up the dinner roll on a resident's plate and break it apart. She was not observed to wash her hands before handling the resident's eating utensils or before donning the pair of disposable gloves.</p> <p>At 11:39 a.m., Caregiver #4 was observed to pull a chair over to a table and begin to feed a resident. She was not observed to wash her hands after touching the chair.</p> <p>At 11:39 a.m., Caregiver #3 was observed to move a resident's Geri-chair at a dining room table to a more upright position. She was observed to handle the drinking glasses of a resident also seated at the table. She was then observed to feed the resident seated in the Geri-chair. She was not observed to wash her hands after moving the Geri-chair and before handling the drinking glasses and starting to feed the resident.</p> <p>At 11:45 a.m., Caregiver #3 was observed to leave the dining room table where she was feeding a resident, pick up a key, and enter the Hickory Ridge neighborhood pantry which was located in a common hallway next to the dining</p>		<p>potentially contaminated surface by DNS/designee which included a skills validation return demonstration. Nursing staff received re-education on acceptable and unacceptable items to be stored in the freezer section of pantry refrigerators and on properly sealing, labeling and dating of food and beverages in the pantry freezers/refrigerators in the neighborhoods. Dietary Manager, Clinical Nurse Leaders, and DNS/designee are responsible to ensure hand washing procedures are followed.</p> <p>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>A QA assessment tool will be utilized weekly x 4, monthly x 2, and quarterly thereafter to monitor appropriate handwashing during meals, and to monitor freezers/refrigerators on each neighborhood pantry.</p> <p>Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p>	

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	<p>room. She was observed to return to the dining room with a nutritional supplement for the same resident she had been feeding. She was observed to sit next to the resident and feed her the nutritional supplement. She was not observed to wash her hands after returning to the dining room.</p> <p>3. During an observation of the Birchwood neighborhood pantry on 6/5/15 at 9:12 a.m., the freezer section of the refrigerator contained: 4 frozen bottles of water that were not labeled, 3 milkshakes from a local restaurant that were not labeled and not dated, a covered bowl of ice cream with topping that was not labeled and not dated, and an opened 19.8 ounce bag of tator tots that was not labeled and not dated.</p> <p>4. During an observation of the Cherry Park neighborhood pantry on 6/5/15 at 9:18 a.m., the freezer section of the refrigerator contained: a microwaveable meal of spaghetti and meatballs that was not labeled and a plastic bag containing a hot/cold bed buddy (a tubular shaped piece of faric filled with a material, unable to be sanitized, and to be used for resident care.</p> <p>5. During an observation of the Chestnut neighborhood pantry on 6/5/15 at 9:21</p>		<p>Compliance date: July 10, 2015</p>	

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	<p>a.m., the freezer section of the refrigerator contained: a 14 ounce container of ice cream that was not labeled and was not dated.</p> <p>6. During an observation of the Hickory Ridge neighborhood pantry on 6/5/15 at 9:26 a.m., the refrigerator contained: an opened 16 ounce bottle of a super drink that were not labeled and not dated, and a thermal lunch box, containing a breakfast bar, a 16.9 ounce bottle of water and a 16.9 ounce bottle of iced tea, were not labeled.</p> <p>7. During an observation of the Maple Cove neighborhood pantry on 6/5/15 at 9:31 a.m., the refrigerator contained: a large plastic sport type water bottle that were not labeled, and a red and black lunch tote, containing string cheese, yogurt, and a microwaveable meal of lasagna with meat sauce, were not labeled.</p> <p>8. During an observation of the lunch meal in the Magnolia Manor dining room, the following was observed:</p> <p>At 11:36 a.m., Caregiver #6 was observed to lather her hands for 13 seconds prior to rinsing. She was observed to don a pair of disposable gloves before picking up soiled tissues</p>			

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	<p>from a dining room table.</p> <p>At 11:38 a.m., Caregiver #6 was observed to remove the disposable gloves and lather her hands for 7 seconds prior to rinsing. She was then observed to remove a clean clothing protector from a resident and help Caregiver #5 assist the resident to the bathroom.</p> <p>At 11:50 a.m., Caregiver #6 was observed to re-enter the dining room and lather her hands for 8 seconds prior to rinsing. She was observed to replace the clean clothing protector on the resident who she assisted to the bathroom.</p> <p>At 11:51 a.m., Caregiver #6 was observed to pull a chair in-between 2 residents seated at a dining room table. She was observed to pick up a flow control cup of the resident assisted to the bathroom, un-roll her eating utensils from her napkin, pick up her eating utensils and begin to feed the resident. She was then observed to leave the dining room table, re-fill the flow control cup with juice, return to the dining room table, hand the flow control cup to the resident, and resume feeding her. She was not observed to wash her hands.</p> <p>9. During an observation of the lunch meal in the Hickory Ridge dining room on 6/1/15, the following was observed:</p>			

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	<p>At 11:22 a.m., Caregiver #4 was observed to lather her hands for 10 seconds prior to rinsing. She was then observed to assist a resident to eat their meal.</p> <p>At 11:21 a.m., Caregiver #14 was observed to lather her hands for 10 seconds prior to rinsing. She was then observed to continue assist a resident eat their meal.</p> <p>10. During an observation of the lunch meal on 6-1-2015 in the Magnolia Manor dining room, the following was observed:</p> <p>At 11:22 a.m., Caregiver #7 was observed to lather her hands for 10 seconds and and rinse for 10 seconds. She was observed to sit in a chair between 2 residents and placed her hands folded in her lap and against her pant legs. She was observed to move a chair by placing her hands on the back of the chair and sat down and began feeding a resident her lunch without re-washing her hands.</p> <p>At 11:29 a.m., Dietary #13 was observed to pick up a resident's used napkin from the floor and discard it in the trash. Dietary #13 washed his hands by lathering with soap for 10 seconds, rinsing for 5 seconds and then served a</p>			

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	<p>resident her meal.</p> <p>At 11:31 a.m., Dietary #13 used a key to unlock the pantry door, obtained a can of soft drink for a resident, returned to the dining room and without washing his hands, Dietary #13 obtained a glass, filled it with ice and served the glass of ice to a resident.</p> <p>At 11:34 a.m., Dietary #13 was observed to use a key to unlock the pantry door, obtained a can of soft drink for a resident, returned to the dining room and without washing his hands, Dietary #13 obtained a glass, filled it with ice and served the glass of ice to a resident. The pantry was located outside the dining area in a common hallway .</p> <p>11. During an observation of the lunch meal on 6-2-2015 in the Magnolia Manor dining room, the following was observed:</p> <p>At 11:23 a.m., Caregiver #8 was observed to move a resident's wheelchair and assist another resident with his wheelchair and positioned him at a table. Without washing her hands, Caregiver #8 was observed to pour milk and apple juice into glasses and served them to a resident. Caregiver #8 went to the medication cart for ice water and was observed to fill and serve 3 residents ice</p>			

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	<p>water. Caregiver #8 poured another glass of a red liquid and served it to a resident. Caregiver #8 obtained the keys to the pantry and went into the pantry to obtain a container of thickened liquid. Caregiver #8 was observed to serve a glass of the thickened liquid to a resident. Further observations of Caregiver #8 indicated she placed her right hand on the back of a chair, then placed her left hand on the back of the chair, rubbed her nose, grabbed her pen with her right hand and wrote on a paper towel and without washing her hands sat down next to a resident and picked up the resident's cup and assisted the resident with her drink.</p> <p>At 11:32 a.m., Caregiver #8 was observed to take a covered plate to a resident's room and without handwashing her hands or using hand hygiene, Caregiver #8 cut up the resident's food with the silverware.</p> <p>12. During an observation of the dinner meal on 6-3-2015 in the Cherry Park dining room, the following was observed:</p> <p>At 4:13 p.m., Caregiver #9 was observed standing to feed a resident. Caregiver #9 was observed to get a chair, push the back of the chair with her hands and since it would not fit in the area where the resident was sitting, she pushed the</p>			

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	<p>chair back to its' original place.</p> <p>Caregiver #9 sat in another chair next to the resident and without washing her hands, picked up the resident's fork to feed the resident.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 6/5/15 at 1:10 p.m. During the interview he indicated staff were to lather their hands for 20 seconds out of the water before rinsing. He also indicated staff were to wash their hands in-between changing tasks. He further indicated food and beverages in the neighborhood pantries were to be labeled and dated and only food items were to be stored in the freezer. Staff could keep their lunch items in the freezers and refrigerators, but they must be labeled.</p> <p>A current facility policy "Handwashing", with a revision date of 2/13/15 and provided by the CDM on 6/5/15 at 8:35 a.m., indicated "...All team members who have direct contact with residents or food will wash their hands for at least 20 seconds before beginning work...Procedure: Wet hands with warm running water. Apply hand washing soap and distribute over hands. Vigorously rub hands together 20 seconds, generating friction on all surfaces of the hands and fingers, including thumbs, back of the fingers, back of the hands, and beneath</p>			

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	<p>finger nails...When to Wash Hands...Before and after personal use of the toilet or before and after assisting a resident with toileting...Before assisting a resident to eat or drink...After handling any contaminated items...After handling soiled equipment or utensils...After removing gloves or aprons...." The policy did not indicate hands were to be washed prior to donning disposable gloves.</p> <p>A current facility policy "Storage in Pantry Fridge/Freezer", with a revision date of 6/6/15 and provided by the CDM on 6/8/15 at 8:35 a.m., indicated "...All items stored in the pantry fridge and freezers must have a date and be marked with a name if residents or employees use it for food storage...Procedure...When putting open food items in the the fridge it must be marked with the date it's placed there. If a resident or their family wish to put food items there it must be marked with the date and name of the resident. If employees wish to put food for lunches and breaks there it must be marked with the date and name of employee..." The policy did not indicate non-food items were not to be stored in the pantry refrigerators and freezers.</p> <p>3.1-21(i)(1)</p>			

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F 0431 SS=E Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and</p>	F 0431	F431 Drug Records, Label/Store Drugs &	07/10/2015
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	<p>record review, the facility failed to ensure a narcotic count was maintained in an accurate manner for 1 of 5 clinical units reviewed. The facility further failed to ensure OTC (over the counter) medications were labeled appropriately for 2 of 9 medication and treatment carts observed, and failed to ensure treatment ointments, gels and a disinfectant were stored separately from oral medications for 1 of 9 medication and treatment carts observed.</p> <p>Findings include:</p> <p>1. On 6/3/15 at 3:30 p.m., the following observations were made with LPN #29: On C wing Birchwood unit, the following OTC (over the counter) medications were observed without a physician name on the bottle: MVI (multi vitamin), Calcium 600 +D. The following prescription medication bottles lacked a physician name: Carvedilol 6.25 mg (milligrams), Synthroid 0.1 mg, Isosorbide 30 mg Extended Release and Hydrochlorothiazide 12.5 mg. LPN #29 was interviewed at the time and indicated this resident had brought these medications to the facility and they were from a mail order pharmacy. These medications were observed to be in amber colored medication bottles with white lids and had a printed label on each</p>		<p>Biologicals</p> <p>It is the practice of this provider, through the services of a licensed pharmacist, to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determine that drug records are in order and an account of all controlled drugs is maintained and periodically reconciled. Further, this provider ensures that OTC medications are labeled and stored appropriately.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>The narcotic count was investigated and corrected by DNS and charge nurse immediately when the error was reported. Over the counter labels were corrected for the two residents cited. The disinfectant, treatment ointment, and gel were properly placed away from the oral medications in all cited medication carts.</p> <p>How other residents having the</p>	

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	<p>of them but the label lacked a physician name. A 200 tablet bottle of Calcium Vitamin D3 did not have an identifying resident name on it. The bottle was observed to have a partial label, but the resident's name had come off the label.</p> <p>On C wing Oak unit, the following was observed on 6/3/15 at 3:45 p.m.: The medications Antacid Alkum, OTC Aspirin 81 mg, OTC bottle of Acetaminophen 500 mg, OTC of Vitamin D 1000 IU (international units) and Preservision were lacking the physician name on the bottle.</p> <p>On 6-3-2015 at 3:50 p.m., the narcotic count was randomly checked. A bubble pack card of Tramadol 50 mg, 1/2 tablets (25 mg) was observed. The physician order on the card indicated the Tramadol 50 mg was ordered to be given 1/2 tab routine bid (twice a day) and then every 4 hours as needed. There were 23 tablets observed in the bubble pack card for Tramadol. When this was compared to the corresponding sign out log sheet, the log indicated there should be 24 pills on the card. LPN #29 was made aware of the discrepancy, and she indicated she had given the resident a dose of this medication this morning at 8 a.m. Documentation on the "Controlled Substance Record" indicated on 6/3/15 at</p>		<p>potential to be affected by the alleged deficient practice will be identified and what corrective actions will be taken</p> <p>1. Narcotic accounting: All residents with current orders for controlled drugs can be affected. A thorough reconciliation of all narcotics in the facility was completed.</p> <p>2. Medication labeling: All residents with over the counter medications or outside pharmacy medications have the potential to be affected. A comprehensive audit of all OTC medications and outside pharmacy medications was completed and labeling now includes all required information.</p> <p>3. Medication storage: All residents having oral medications stored in the carts have the potential to be affected. All medication carts have been thoroughly inspected and non-oral products are now storage separately from oral medications.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur</p> <p>A new policy has been developed regarding proper OTC/Pharmacy</p>		

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	<p>8 a.m., LPN #29 had signed out a Tramadol, with the count after the medication was removed to be 24 tablets. At this time, LPN #29 indicated she was unaware as to "how the count could be off." LPN #29 then began looking for the missing tablet of Tramadol in the drawers of the medication cart. She was unable to locate the missing pill of Tramadol. LPN #29 indicated when she counted the narcotics this morning with the night shift nursing staff, LPN #29 looked at the card which had the pills on it and the night shift nursing staff counted from the controlled substance record.</p> <p>On 6-3-2015 at 3:55 p.m., LPN #29 notified the DNS (Director of Nursing Services) of the discrepancy in the narcotic count. At 3:57 p.m. the DNS arrived at the unit and reviewed the resident's MAR (medication administration record).</p> <p>On 6/3/15 at 4:22 p.m., the DNS was interviewed. She indicated on 5/31/15 at 4 p.m. a dose of Tramadol had been given, as indicated on the MAR but just "wasn't signed out" on the controlled substance record. She indicated the documentation on the controlled substance record on 5/31/15 was lacking documentation of the Tramadol having been signed out at 4 p.m. She indicated</p>		<p>labeling requirements. A mandatory in-service for all licensed nurses and QMA's regarding this policy, as well as proper medication storage and controlled drug reconciliation has been completed. Clinical Nurse Leaders and the DNS/Designee are responsible for ensuring compliance with facility policy.</p> <p>How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>A QA assessment tool will be utilized 5 days / week x 4 weeks, once weekly x 2 months, then once monthly x 3 months by DNS/Designee to monitor accuracy of narcotic counts, medication labeling and medication storage in all medication and treatment carts. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p> <p>Compliance date: July 10, 2015</p>				

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	<p>this was why the controlled substance log had one more pill documented than was actually available on the medication card. She indicated the narcotic count had been off from 5/31/15 at 10 p.m. until this date, 6/3/15 and this time when the error was found.</p> <p>On 6/3/15 at 5:05 p.m., the C.O. (compliance officer) provided a copy of the May 2015 and June 2015 Shift Narcotic count Sheets. Documentation indicated the narcotics had been counted each of the three shifts for the following days: 5/31/15, 6/1/15, 6/2/15, 6/3/15 and for the night to day shift on 6/3/15.</p> <p>On 6/4/15 at 9:00 a.m., the DNS provided a copy of the current facility policy and procedure for "Inventory Control of Controlled Substances." The policy had a revision date of 1/1/13 and included but was not limited to, the following: "...Facility should ensure that the incoming and outgoing nurses count all...controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on the "Count Verification/Shift Count Sheet...reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift</p>			

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	<p>count sheet..."</p> <p>2. During an observation of the medication cart in Maple Cove, the memory unit, with LPN #15 on 6/3/15 at 3:29 p.m., the following was observed: In the bottom drawer of the medication cart was an opened OTC (Over the Counter) bottle of Therm Vital M (a multivitamin) not labeled with a resident's name or a physician's name. In the bottom drawer of the medication cart was an opened bottle of Acetaminophen 500 mg, 200 count with a Resident's first name and last initial written on the cap of the bottle. The bottle of Acetaminophen was not labeled with the physician's name.</p> <p>An interview with LPN #15 on 6/3/15 at 3:33 p.m. indicated the medications stored in the bottom drawer of the medication cart were overflow or discontinued medications. She also indicated it appeared the label had come off of the bottle of Therm Vital M. She further indicated she could not determine which resident had the Therm Vital M. LPN #15 indicated all OTC medications were to be labeled with the resident's name, physician's name, room number</p>			

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	<p>and an opened date.</p> <p>3. During an observation of the medication cart in Peach Tree Unit, the rehabilitation unit, with LPN #16 on 6/3/15 at 4:00 p.m., the following was observed: The treatment creams and ointments and gels were stored in the same drawer with the oral medications. An interview with LPN #16 on 6/3/15 at 4:05 p.m., indicated there were only a few residents on the rehabilitation unit and she further indicated there was no need for a separate treatment cart.</p> <p>During an observation of the medication cart in Peach Tree Unit with LPN #17 on 6/8/15 at 2:30 p.m., the following was observed:</p> <p>An opened tube of Vasolex Ointment (for wound debridement) was opened on 5/9/15 and the tube had dried ointment around the bottom of the cap. The tube was not in a plastic bag and was in the drawer with the oral medications.</p> <p>An opened tube of Silvasorb Gel 1.5 (an antimicrobial treatment) and an opened tube of FungiCure Liquid Gel (an antifungal treatment) were stored in a disposable plastic cup in the medication cart beside the oral medications.</p>			

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	<p>A container of Clorox Dispatch Disinfectant Towels with Bleach, 150 count was stored in the medication cart with the oral medications.</p> <p>An interview with LPN #17, indicated the treatment ointments and gels should not be stored in the medication cart in the same drawer with the oral medications.</p> <p>An interview on 6/8/14 at 2:39 p.m. with CNL (Community Nurse Leader) #18 indicated the treatment creams and ointments should not be stored in the same cart as the other medications.</p> <p>A review of the current facility's policy provided by the DNS on 6/3/15 at 4:26 p.m., titled, 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, with a revision date of 01/01/13, indicated, "...Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals....Topical(external) use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration....Facility should ensure that test reagents, germicides, disinfectants, and other household substances are stored separately from medications...."</p>			

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F 0520 SS=F Bldg. 00	<p>A review of the current facility's policy, provided by the Compliance Officer on 6/8/15 at 2:45 p.m., titled Packaging and Labeling, with a revision date of 11/3/06, indicated, "...Over the counter medications must be identified with the following: A. Resident's full name, B. Physician's name...."</p> <p>3.1-25(j) 3.1-25(l)(1)(2) 3.1-25(m) 3.1-25(n)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with</p>			

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	<p>the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility's QAA (Quality Assessment and Assurance) Committee failed to identify and implement action plans for the identified concerns regarding the following: chemicals and personal care items accessible to confused and independently mobile residents, a resident seated at a table with the proper height and had appropriate eating utensils to feed herself and an appropriate drinking glass; weekly skin assessments were done and documented and notification of a change in the status of a pressure ulcer to the physician; medications were stored separately from treatment medications, properly labeled over-the-counter medications, adequate handwashing during meal services, and properly stored and labeled food, beverages and non-food items in the facility's pantries. This had the potential to affect 104 of 104 residents who resided at the facility.</p> <p>Findings include:</p> <p>The QAA Committee consisted of the President/CEO (Chief Executive Officer), the Corporate Compliance Officer, the</p>	F 0520	<p>F520</p> <p>The facility maintains a Quality Assessment and Assurance Committee that meets at least quarterly, identifies quality issues, and develops and implements corrective actions plans.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>Refer to corrective actions identified for residents affected by the deficient practices cited at F157, F309, F314, F315, F323, F371, and F431 submitted in this plan of correction.</p> <p>How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions will be taken</p> <p>All residents have the potential to be affected by deficient practices</p>	07/10/2015

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	<p>Administrator, the Medical Director, the Pharmacy Consultant and the managers of the facility's departments met quarterly and failed to identify and implement action plans to correct and monitor the following: Ensuring chemicals and personal care items were not accessible to confused and independently mobile residents; a resident seated at a table with the proper height and had appropriate eating utensils to feed herself and an appropriate drinking glass; weekly skin assessments were done and/or documented and notification of a change in the status of a pressure ulcer to the physician; medications were stored separately from treatment medications, properly labeled over-the-counter medications, adequate handwashing during meal services, properly stored and labeled food, beverages and non-food items in the facility's pantries.</p> <p>An interview with the Corporate Compliance Officer on 6/8/15 at 4:45 p.m., indicated the QAA Committee met quarterly. She indicated the facility's management staff met every morning, Monday through Friday, and reviewed any concerns that were reported, reviewed falls, and infections. She also indicated the facility had a Weekly Risk Management Meeting which reviewed skin conditions, weight loss, therapies,</p>		<p>not identified and acted upon by the QA Committee. Refer to corrective actions identified for potential residents submitted in this plan of correction at F157, F309, F314, F315, F323, F371, and F431.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur</p> <p>The facility-wide Quality Assurance program has been reviewed and revised as deemed necessary to ensure written procedures are in place for early identification of staff practices that could have a negative effect on the physical, mental, or psychosocial well-being of the residents. The QA Committee has met and is now aware of program revisions including but not limited to the types of data each member will be responsible for gathering prior to the quarterly meetings, and the responsibility each member has in developing and implementing appropriate and effective action plans for identified deficient practices.</p> <p>How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality</p>				

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F 9999 Bldg. 00	<p>infections, falls. She indicated the findings from these committees were brought to the QAA Committee Meetings along with the audits done by each of the facility's departments. She indicated the identified concerns were reviewed by the QAA Committee for the root cause to determine when an action plan was developed and implemented. She indicated currently the QAA Committee was reviewing pressure ulcers, wounds and a lack of documentation for the assessments. She also indicated the QAA Committee had worked on hand washing in the past and would need to develop an action plan again along with action plans for the identified deficiencies found during the survey.</p> <p>3.1-52(a)(2)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment.</p>			F 9999	<p>assurance program will be put into place</p> <p>Applicable committee members or designees have been assigned responsibility for monitoring the effectiveness of this plan of correction through use of QA audit tools as explained at F157, F309, F314, F315, F323, F371, and F431. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action.</p> <p>Compliance date: July 10, 2015</p> <p>State Finding</p> <p>F9999</p> <p>The facility requires a physical examination of each employee within one month prior to employment, and maintains employee health records</p>		07/10/2015

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	<p>(3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination;</p> <p>Based on record review and interview, the facility failed to ensure 3 of 5 newly hired staff received a health screening prior to the start of employment.</p> <p>Findings include:</p> <p>Five newly hired employee files were reviewed on 6/4/15 at 2:05 p.m.. The employee files for Cook #22, RN #23, and RN #24 did not contain a physical exam.</p> <p>Human Resources was interviewed on 6/4/15 at 3:40 p.m. During the interview, she indicated a physical exam could not be located for Cook #22, RN #23, and RN #24 and their files did not contain a physical exam.</p> <p>A current undated facility policy "Employee Handbook:, provided by the Director of Nursing Services on 6/5/15 at 10:09 a.m., indicated "...The Indiana State Department of Health requires a ...physical exam signed by a physician...."</p>		<p>including a report of the pre-employment physical examination.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>No residents were cited as affected by the deficient practice.</p> <p>How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions will be taken</p> <p>All residents have the potential to be affected if an employee does not meet the physical health requirements of employments. All pre-employment physical examinations and tuberculosis screening has been completed for new hires since the survey exit date of June 10, 2015.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur</p> <p>Facility policy regarding the pre-employment physical health screening has been revised as well as the language in the</p>		

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey.	R 0000	<p>employee handbook. A new process has been implemented to ensure physical examinations are completed timely as per the policy. The Human Resource Director is familiar with the new policy, and is responsible for ensuring it is followed.</p> <p>How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>A QA Audit Tool will be utilized monthly x 6 to ensure pre-employment physical examinations are completed timely. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for and frequency of on-going audits will be determined based upon compliance rates.</p> <p>Compliance date: July 10, 2015</p> <p>The creation and submission of this Plan of Correction is not an admission by this provider of any conclusion set forth in the</p>	

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R 0121 Bldg. 00	<p>Residential Census: 41 Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result 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</p>		<p>statement of deficiencies, or of any violation of regulation. The Plan of Correction is submitted because of requirements under the State or Federal law. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after July 10, 2015. Our documents for verification of compliance will be attached, or those referenced but not attached will be sent through Gateway or delivered to Kim Rhoades via USPS on or before July 10, 2015.</p>	

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	<p>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>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure 2 of 5 newly hired staff received a health screening prior to the start of employment.</p> <p>Findings include:</p> <p>Five newly hired employee files were reviewed on 6/4/15 at 2:10 p.m. The employee files for Dietary Aide #25 and Cook #26 did not contain a physical exam.</p> <p>Human Resources was interviewed on 6/4/15 at 3:40 p.m. During the interview, she indicated a physical exam could not be located for Dietary Aide #25 and Cook #26 and their files did not contain a</p>	R 0121	<p>R 121 Personnel – Noncompliance</p> <p>It is the practice of this provider to require a health screening of newly hired staff prior to the start of employment.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>No residents were cited as affected by the deficient practice.</p> <p>How other residents having the potential to be affected by the alleged deficient practice will be identified and what</p>	07/10/2015

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	<p>physical exam.</p> <p>A current undated facility policy "Employee Handbook", provided by the Director of Nursing Services on 6/5/15 at 10:09 a.m., indicated "...The Indiana State Department of Health requires a ...physical exam signed by a physician...."</p>		<p>corrective actions will be taken</p> <p>All residents have the potential to be affected if an employee does not meet the physical health requirements of employment. All pre-employment physical examinations and tuberculosis screening has been completed for new hires since the survey exit date of June 10, 2015.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur</p> <p>Facility policy regarding the pre-employment physical health screening has been revised as well as the language in the employee handbook. A new process has been implemented to ensure physical examinations are completed timely as per the policy. The Human Resource Director is familiar with the new policy, and is responsible for ensuring it is followed.</p> <p>How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>A QA Audit Tool will be utilized monthly x 6 to ensure pre-employment physical</p>		

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R 0216 Bldg. 00	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance</p> <p>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on interview and record review, the facility failed to ensure a Self Administration of Medications Test and Steps for Self Administration assessment form was completed for 3 of 6 residents who self administered medications out of 8 records reviewed. (Resident #3, #5 and</p>	R 0216	<p>examinations are completed timely. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for and frequency of on-going audits will be determined based upon compliance rates.</p> <p>Compliance date: July 10, 2015</p> <p>R 216 Evaluation-Noncompliance</p> <p>It is the practice of this provider to ensure a Self-Administration of Medications Test and Steps for Self Administration assessment form is completed on all residents</p>	07/10/2015

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	<p>#8)</p> <p>Findings include:</p> <p>1. During a closed record review of Resident #3's record, the Physician Orders were signed by the physician on 11/6/2014 and indicated "...may keep meds in apartment for self administration...may self admin [sic] medications..." Diagnoses included but were not limited to congestive heart failure, peripheral neuropathy, cognitive impairment and edema.</p> <p>Resident #3 was admitted to the Assisted Living facility on 11-7-2014 and discharged from the facility on 4-6-2015.</p> <p>A review of the nurse's notes dated 11-7-2014 for Resident #3 indicated "...will adm [sic] own medications..."</p> <p>A review of the "Level of Service Assessment/Evaluation - Full List of Items Assisted Living" for 10-29-2014 and 3-2-2015 indicated "0" points for "No Medication Procedures."</p> <p>A review of the Resident Needs and Preference Sheet provided by Community Nurse Leader #28 on 6-9-215 at 2:58 p.m., indicated under "Medication Procedures: self admin..."</p>		<p>who self-administer medications.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>Resident #3 was a closed record. We were unable to correct the alleged deficiency for this resident.</p> <p>Residents # 5 and #8 had a new Medication Assessment Tool completed, and have signed a new Self-Administration of Medications form along with their POA. Copies of these forms were given to the surveyor team during the survey.</p> <p>How will you identify other residents having the potential to be affected by the alleged deficient practice and what corrective action will be taken</p> <p>The charts of all residents who self-administer medications have been reviewed and an evaluation of their ability to safely self-administer medications per the Medication Assessment Tool is in place.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</p>	

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	<p>A review of Resident #3's closed record indicated there was not a "Self Administration of Medications Test & Steps for Self Administration" completed at the initial move in.</p> <p>An interview with the Community Nurse Leader #28 on 6-9-2015 at 2:25 p.m., indicated the "Self Administration of Medications Test & Steps for Self Administration" could not be found for the Resident #3, who self administered his medications.2. During the initial tour of the facility on 6/9/15 from 8:55 a.m. to 9:30 a.m., the CNL (Community Nurse Leader) #28 indicated the following: Resident #5 and Resident #8 are married and share an apartment. Resident #5 was determined to be alert, oriented and reliable for interview. Resident #8 was not identified as being alert, oriented and reliable for interview. CNL #28 indicated at this time, Resident #5 gave resident #8 his insulin.</p> <p>On 6/9/15 at 9:50 a.m., Resident #5 was interviewed. She indicated their daughter fills enough insulin syringes for Resident #5 for 7 days of injections and placed them in the refrigerator in their apartment. Resident #5 indicated she would take out a syringe when Resident #8 was supposed to have an insulin</p>		<p>Facility policy regarding Self Administration of Medications has been revised to reflect compliance with the regulation. All residents who desire to self-administer medications will be assessed on their ability to safely self-administer medications at the time of admission, every 6 months and with any significant change of condition. A Self-Administration of Medications Test & Steps for Self-Administration form will be signed by the resident and/or the responsible party upon admission and will be placed in the resident's medical record. Licensed nurses were re-educated on completing the form and assessment on admission and placing the form in the medical record by the DNS/designee. The designated Community Nurse Leader will be responsible for ensuring compliance with facility policy.</p> <p>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>A QA assessment tool will be utilized weekly x 4, monthly x 2 then quarterly thereafter, to monitor compliance with medication self-administration. Audit results will be reviewed by</p>				

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	<p>injection and would give the syringe to Resident #8. Resident #5 indicated Resident #8 administered the insulin injection to himself.</p> <p>On 6/9/15 at 2:22 p.m., CNL #28 was interviewed. She indicated residents who self administer medication were to have a "Self-Administration of Medications Test and Steps for Self Administration" form completed. She indicated she was unable to locate the "Self-Administration of Medications Test and Steps for Self Administration" for either Resident #5 or Resident #8. She indicated she thought this form had been completed upon Resident #5 and Resident #8's admission to the facility, which was on 12/11/14.</p> <p>On 6/9/15 at 3:30 p.m., the Admission record and current physician orders for Resident #8 were reviewed. It included, but was not limited to, the following: "Admitting diagnosis:...Alzheimer's...condition on admission:...alert, forgetful, confused..." The physician orders included, but were not limited to, the following: "...12/23/14: Wife/family to administer medications..."</p> <p>On 6/10/15 at 9:04 a.m., the C.O. (compliance officer) was interviewed. She indicated they were still unable to</p>		<p>the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for and frequency of on-going audits will be determined based upon compliance rates.</p> <p>Compliance date: July 10, 2015</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815
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	<p>find the "Self-Administration of Medications Test and Steps for Self Administration" for either Resident #5 or Resident #8.</p> <p>On 6/10/15 at 9:50 a.m., the C.O. was interviewed. She indicated the nursing staff should actually have observed the resident who was being evaluated for medication self administration per the facility policy and procedure.</p> <p>On 6/10/15 at 10:20 a.m., the "Self-Administration of Medications Test and Steps for Self Administration" , dated 6/10/15 included, but was not limited to, the following: "...The resident above (Resident #8) has been tested for each medication ordered. He/She has successfully demonstrated/communicated the following: when and how to use the drug..." On the bottom of this form was a handwritten note "(name of Resident #8) wife and children assist with medications and insulin."</p> <p>A current policy "Self Administration of Medications" dated 2005 and provided by the Community Nurse Leader #28 on 6-9-2015 at 2:58 p.m., indicated the following: "...Residents who desire self-administration and who can safely demonstrate ability to self-administer</p>			

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R 0356 Bldg. 00	<p>their medication are allowed to do so based upon (facility) protocol. Community Nurse Leader/Neighborhood nurses will screen each resident requesting Self-Administration of Medications to determine if they qualify...Procedure...Storage of medications in a resident's apartment is permitted with a physician's order for those residents qualified to self-administer...Self administration of medication is permitted for those residents who request to take their won [sic] medication and are deemed alert and responsible in self-administration...a physician order must always be secured to self-administer...Appropriate evaluation of the residents' ability to self-administer should be performed and recorded upon move in or upon determination a resident request [sic] self-administration of medication, every 6 months...Each resident will be administered a test, steps for self-administration and sign a release form before they may self-administer their medications...."</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident,</p>			

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	<p>in case of emergency, that contains the following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</p> <p>(2) The resident ' s hospital preference.</p> <p>(3) The name and phone number of any legally authorized representative.</p> <p>(4) The name and phone number of the resident ' s physician of record.</p> <p>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on interview and record review, the facility failed to maintain a complete emergency information file containing a photograph of each resident, potentially affecting 41 of 41 residents in the facility.</p> <p>Findings include:</p> <p>The facility Emergency Resident Information file was reviewed on 6/10/15 at 9:30 a.m.. During the review it was noted there were no photographs of the 41 residents residing in the facility.</p> <p>The Compliance Officer was interviewed on 6/10/15 at 9:45 a.m. During the interview she indicated she was not certain why photographs of the residents</p>	R 0356	<p>R 356 Clinical Records - Noncompliance</p> <p>It is the practice of this provider to maintain a complete emergency information file that contains a photograph of each resident in case of emergency.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>All 41 residents currently residing in the facility were photographed and the photographs were placed in the emergency information file.</p> <p>How other residents having the</p>	07/10/2015

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	were not in the emergency resident information file.		<p>potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken</p> <p>Future admission to the residential care facility can be affected. 41 residents currently residing in the facility were photographed and the photographs were placed in the emergency information file.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur</p> <p>Facility policy regarding information including photographs in the Emergency Evacuation Forms was revised to ensure compliance with this regulation. Applicable staff has been in-serviced on the policy. The designated Community Nurse Leader will be responsible for ensuring compliance with facility policy.</p> <p>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>A QA tool will be utilized weekly x</p>	

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			4, monthly x 2, and quarterly, thereafter, to monitor compliance. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for and frequency of on-going audits will be determined based upon compliance rates. Compliance date: July 10, 2015		