

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155118	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 787 N DETROIT ST LAGRANGE, IN 46761
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 23, 24, 25, 26, and 29, 2014</p> <p>Facility number: 000049 Provider number: 155118 AIM number: 100270890</p> <p>Survey team: Sharon Ewing, RN-TC Pamela Williams, RN Julie Baumgartner, RN Shauna Carlson, RN Amy Miller, RN</p> <p>Census bed type: SNF: 5 SNF/NF: 80 Total: 85</p> <p>Census payor type: Medicare: 4 Medicaid: 56 Other: 25 Total: 85</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This plan of correction is submitted to meet requirements established by state and federal law. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 10/29/14.</p>	
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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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F000279 SS=D	<p>Quality Review completed on October 7, 2014, by Brenda Meredith, R.N.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure the care plan of a resident who fell was updated. This affected 3 of 4 residents reviewed for falls. (Resident #26, Resident #44 and Resident # 68)</p> <p>Findings include:</p>	F000279	<p><u>F 279 DEVELOP COMPREHENSIVE CARE PLANS</u></p> <p>-</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive</p>	10/29/2014

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	<p>1. On 9-24-2014 at 11:15 A.M., a record review was conducted of Resident #26's chart. Resident #26 was admitted on 6-3-2013 to the locked dementia unit. Diagnoses included, but were not limited to, "...vascular dementia with delusions, Alzheimer's disease...." MDS assessment (Minimum Data Set-a assessment tool), dated 5-15-2014, indicated a BIMS (Brief Interview for Mental Status) of 4 out of a possible 15, severe cognitive impairment. Physicians medication orders included, "Aspirin tablet delayed release 81 mg [milligram] Give one tablet by mouth one time a day."</p> <p>The Occurrence Initial Assessment, dated 8-5-2014, indicated "...Date and time of occurrence 08/05/2014 at 0645 [6:45 A.M.]...Fall with no injury...Writer heard loud thump, upon investigation, Resident noted to be sitting on buttocks on the floor directly in front of her closed door, with legs straight out in front of her. Resident's roommate stated she witnessed fall, that Resident was stepping sideways at end of bed when she lost balance, her back sliding down end of bed, her buttocks hitting floor, ending up with back against closed room door. Roommate and Resident stated Resident did not hit head. Wearing non-skid shoes, call light within reach, but rolling walker</p>		<p>plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>It is the policy of this facility to develop a Care Plan from the conclusions of assessments and review and revise the care plan as changes in the plan of care arise. The facility develops a plan of care that includes measurable objectives and time tables to meet the resident physical, mental, and psychosocial needs. The Care Plans for Residents listed as found to be affected by this alleged deficiency (#26, #44, #68) have been reviewed and updated to reflect the current interventions that</p>				

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	<p>across room out of reach...Stated mild tenderness to left knee and mid back. No redness or visible injuries noted at this time...Will request therapy screen and med review with Dr. [Medical Directors name] during rounds this evening...Neuro checks started due to hitting head or unwitnessed fall...NO...."</p> <p>A Progress Note, dated 8-5-2014 at 6:17 P.M., indicated "...Resident was seen today for her continued anxiousness and sleeplessness and falls. medications and treatments reviewed...PT/OT [physical therapy/occupational therapy] eval [evaluation] and treat...."</p> <p>A Progress Note, dated 8-6-2014 at 12:24 P.M., indicated "...OT skilled services for 5x 1 week x4 weeks for ADL [Activities of Daily Living} training, neuro re-ed [education], there [therapeutic] exercise and there activities...."</p> <p>A Progress Note, date 8-6-2014 at 6 P.M., indicated "...Physical therapy 5 times per week for 4 weeks, for therapeutic exercises therapeutic activities, neuro [neurological]-re-education and gait training...."</p> <p>The Occurrence Initial Assessment, dated 8-7-2014, indicated "...Date and time of occurrence 08/07/2014 at 0445 [4:45</p>		<p>are in place to reduce risk for falls. Resident #26 was discharged from the facility. The care plan for Resident #44 was updated to include donning shoes or non-skid stockings prior to transfers, use of a gait belt during transfers, assist with toileting needs per plan, and bed height even with W/C height during transfers. The aide involved with this transfer was reminded to use a gait belt while transferring. The aide reported that she did use it for this transfer. Resident #68's care plan was updated to include non-skid foot ware, use of the merry walker as an enabler, assists with toileting needs as per toileting plan.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All residents that reside at this facility have the potential to be affected by the alleged deficient practice.</p> <p>* All licensed staff will be in-serviced on 10/22/2014 by the Director of Nursing and/or her designee on the policy of developing, implementing, reviewing, and revising the care plans for the resident residing at this facility. Post test related to the development, implementation, reviewing, and</p>		

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	<p>A.M.]...Fall with injury... Writer heard loud bang coming from residents room and immediantly [sic] went to check on resident. Upon entering room writer noted resident lying on her back on the floor near the foot of her bed. Resident was not incontinent and was wearing gripper socks. Floor was dry and free of debris. Residents right leg was rotated outward. Resident was stating extreme pain when right hip area was touched. No swelling noted to area. No further injuries noted. NW [North West] nurses placed resident on sliding board and onto her bed. Writer phoned physician and received order to send resident to [name of local hospital] ER [emergency room] for evaluation and treatment per ambulance...."</p> <p>On 9-29-2014 at 12 P.M., an interview was conducted with LPN #4. LPN #4 indicated, "...She [Resident #26] was admitted to Country Meadows [locked dementia unit] in 2013. She fell there and went to the hospital on 8-7-2014 with a hip fracture, she had surgery to fix it and was readmitted on 8-14-2014 to the facility on another unit because she needed more assistance...."</p> <p>On 9-29-2014 at 1 P.M., record review of Resident #26's care plans was conducted. Fall risk care plan, dated 6-5-2013,</p>		<p>revising the care plan will be completed by all licensed nursing staff.</p> <p>* The Director of Nursing and/or her designee will audit that the care plans for all residents having an occurrence within the past 30 days to ensure that appropriate interventions are in place for these residents.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>* The Director of Nursing and/or her designee will complete Quality Assurance audits to ensure that policy and procedures are being followed in relationship to the development, implementation, review, and revision of the care plans for those residents that have fallen or at risk to fall.</p> <p>* All licensed staff will be in-serviced on 10/22/2014 by the Director of Nursing and/or her designee on the policy of developing, implementing, reviewing, and revising the care plans for the resident residing at this facility. Post test related to the development, implementation, reviewing, and revising the care plan will be completed by all licensed nursing staff.</p>				

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	<p>indicated, "...Fall Risk characterized by risk factors decreased safety awareness due to Alz [Alzheimer's] Dementia, History of fall with fracture to lower arm...Interventions...Encourage resident to use handrails or assistive devices properly [created on 6-5-2013]...Reassess fall risk factors at least quarterly [created 6-5-2013]...Monitor for changes in gait/positioning [created on 6-5-2013]...Call light within reach. Explain use of it upon admission and reinforce as needed. [created on 6-5-2013]...Encourage and assist with wearing non-skid foot-wear before getting out of bed. [created on 4-22-2014]...Non-skid strip on the floor next to the bed. [created on 7-30-2014]...."</p> <p>There was no documentation the care plan had been revised after the the falls on 8-5-14 and 8-7-14.</p> <p>On 9-29-2014 at 3:30 P.M., during an interview, the DON (Director of Nursing) indicated, "... it would not be appropriate for a resident with a BIMS of 4 to have an intervention on their care plan that would be a reminder to use their call light...I should have checked the incident with an IDT [Interdisciplinary Team] form that I am supposed to be filling out...I did not know I was supposed to</p>		<p>* The Director of Nursing and/or her designee will audit that the care plans for all residents having a fall with or without injury within the past 30 days to ensure that the appropriate interventions are in place for these residents. This audit will be completed using the Fall Risk Management Review (Attachment #1)</p> <p>* The Director of Nursing and/or her designee will initiate discussion of occurrences during the daily stand up meeting and record on the "Daily Stand Up Meeting" form. (Attachment #2)</p> <p>* The Director of Nursing and/or her designee will conduct a meeting with the interdisciplinary team (IDT) to determine root cause and appropriate interventions. The Post Occurrence IDT and Fall Risk Assessment will be initiated at this time and the Care Plan will be reviewed and revised at the time of this meeting or as soon as possible once interventions can be determined. (Attachment #3)</p> <p>* Non compliance with the policy and procedure for the development, implementation, review, and revision of the care plan procedures may result in further education, and/or disciplinary action.</p> <p>How will the corrective action(s) will be monitored to ensure the</p>	

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	<p>and none has been filled out since this spring...."</p> <p>2. On 9-23-2014 at 2:59 P.M., during an interview, LPN #7 indicated Resident #44 had a fall on 9-17-2014.</p> <p>On 9-25-2014 at 2:45 P.M., a record review was conducted of Resident #44's chart. Resident #44 was admitted on 7-19-2013. Diagnoses included but were not limited to, "...history of falls, hip fracture, Alzheimers disease...." The MDS assessment, dated 7-29-2014, indicated the staff assessment for this resident was cognitively severely impaired.</p> <p>The Occurrence Initial Assessment, dated 9-17-2014, indicated "...Date and time of occurrence 09/17/2014 0615 [6:15 A.M.]...Fall with injury...When writer entered resident's room resident was sitting on her buttocks in front of her bed. Resident was assess while on floor. Was noted to have a scant amt [amount] of blood noted on right side of her forehead with a small purple bruise noted. No other injuries noted @ [at] this time. Resident has good AROM [Active Range of Motion] of all exteremities [sic]. Resident was assisted to standing and assisted to her w/c [wheelchair] with 2 assists. Resident was reassessed @ this</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>* The Director of Nursing and/or her designee will complete Quality Assurance Audits after each occurrence to ensure that interventions were placed on the Care Plan and that the IDT team met and completed the IDT assessment.</p> <p>* The Director of Nursing and/or her designee will use the Quality Assurance Tools "Care Plan Review" (attachment #4) and "Fall Risk Management Review" (Attachment #1) to complete these audits. These audits will occur on a weekly basis for 4 weeks, bi-weekly for 4 weeks and then monthly for all residents identified as at risk for falls.</p> <p>* Any related findings will be reviewed with the Quality Assurance committee during the monthly Quality Assurance meeting.</p> <p>* In addition each reported fall will be reviewed with in 24 hours (72 hours if occurrence was over the weekend) by the IDT (Interdisciplinary Team).</p> <p>By what date the systemic changes will be completed. The completion date for this Plan of Correction is 10/29/2014.</p>				

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	<p>time. No other injuries noted @ this time. Cont [continue] to have good AROM of all extremities. Responds to name well. Neuro's started @ this time. Writer asked BNA [Basic Nurse Aid] and she stated she was attempting to transfer resident from her bed to her w/c when resident grabbed her w/c and resident lost her balance and BNA attempted to break resident's fall without success and resident fell on the floor by her bed and bumbed her right side of her forehead on the corner of her night stand causing a small amt of bleeding with small purple bruise noted. Area was cleansed with soap and water and a bandaid applied. No pain noted @ this time. Resident had shoes on @ the time of the occurrence.</p> <p>Resident #44's care plan for fall risk, dated 9-7-2012, indicated, "...fall Risk characterized by risk factors as listed on the fall risk assessment. History of falls, Confusion/dementia, debility...Interventions...Call light in reach. Explain use of it upon admission and reinforce as needed. [created 9-7-2012]...Encourage resident to use handrails or assistive devices properly [created 9-7-2012]...Monitor for changes in gait/positioning. [9-7-2012]...Notify MD [medical doctor] of changes in condition [created 9-7-2012]...Notify Therapy of changes in condition [created</p>						

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	<p>9-7-2012]...Offer diversional activities PRN [as needed] [created 9-7-2012]...Reassess fall risk factors at least quarterly [created 9-7-2012]...Reinforce need to call for assistance [created 9-7-2012]...Place bed along side of wall. [1-3-2013]...Low Bed with Concave mattress and mat on the floor. Foot pedals added to wheelchair and wedge cushion placed in seat of wheelchair. [1-7-2013]</p> <p>There was no documentation to indicate the care plan had been updated after the fall on 9-17-14.</p> <p>3. On 9-24-2014 at 10:57 A.M., an interview with LPN [Licensed Practical Nurse] #8 was conducted. LPN #8 indicated Resident #68 had a fall in the last 30 days with no injury.</p> <p>On 9-29-2014 at 9:14 A.M., a record review of Resident #68's chart was conducted. Diagnoses included but were not limited to: senile dementia with delusional features, dementia with behaviors, paralysis agitans and altered mental status.</p> <p>The Occurrence Initial Assessment, dated 9-17-2014, indicated "...Date and time of occurrence: 09/17/2014 at 2145 [9:45 P.M.]...Fall with no injury...Heard a bang</p>						

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	<p>in the hallway went to check resident was laying on his back under his merry walker [chair shaped PVC ambulation assisting device] feet straight out arms at his side. Able to respond to questions. Denies pain at this time. Head to toe assessment and vitals done, no injury noted at this time vitals within normal range. Assisted to feet with assistance able to walk on his own...."</p> <p>Resident #68's Fall Risk care plan, dated 9-5-2012, indicated "...Fall Risk characterized by risk factors as listed on the fall risk assessment...Interventions:...Reinforce need to call for assistance [created on 9-5-2012]...Evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication [created on 9-5-2012]...Analyze previous resident falls to determine whether pattern/trend can be addressed [created on 9-5-2012]...Reassess fall risk factors at least quarterly [created on 9-5-2012]...Notify MD [Medical Doctor] of changes in condition [created on 9-5-2012]...Notify Therapy of changes in condition [created on 9-5-2012]...Monitor for changes in gait/positioning [created on 9-5-2012]...Call light in reach. Explain use of it upon admission and reinforce as</p>			

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	<p>needed [created 9-5-2012]...Encourage frequent rest periods when Resident ambulating for prolonged periods [created on 8-25-2013]...Referral for therapy to evaluate resident due to recent falls sent out [created on 2-18-2014]...Encourage rest periods after meals [created on 2-18-2014]...Keep halls with proper lighting while resident is pacing at night time [created on 5-26-2014]...Physician to review medications due to diagnosis of insomnia [created 7-9-2014]...Request therapy screen [created on 8-13-14]...Safety-Shoes/slippers on before walking [created on 3-5-2013]...."</p> <p>There was no documentation to indicate the care plan had been updated after the fall on 9-17-14.</p> <p>On 9/25/14 at 3:48 P.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated it is the responsibility of the nurse filling out the initial occurrence to update the careplan, then it is taken to stand up meeting and reviewed further.</p> <p>On 9/29/14 at 9:30 A.M., a policy, provided by the Director of Nurses, titled "... Care Plan Development & Review with start date of 2014-02...." was reviewed. The policy indicated but was</p>			

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F000280 SS=D	<p>not limited to the following: "... CARE PLAN REVISION: A. Care plans will be revised daily and PRN as changes in the resident's condition dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin changes etc...."</p> <p>3.1-35 (d)(2)(B)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to revise the careplan of a resident who had experienced a weight loss for 1 of 3 residents reviewed for weight loss. (Resident # 95)</p>	F000280	<u>F- 280 Right to Participate Planning Care- Revise CP</u>	10/29/2014

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 787 N DETROIT ST LAGRANGE, IN 46761			
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	<p>Finding includes:</p> <p>On 9/25/14 at 3: 42 P.M., the clinical record for Resident # 95 was reviewed. The electronic clinical record indicated Resident # 95 was admitted on 5/28/14 with diagnosis including, but not limited to the following: dementia, unspecified, with behavioral disturbance, vascular dementia with delusions, depressive disorder, constipation, pure hypercholesterolemia and unspecified urinary incontinence.</p> <p>A weight note concern, dated 7/11/14 at 13:23 (1:23 P.M.) indicated, but was not limited to the following:"...Resident's weight has decreased. He currently had a regular diet. Will add pudding snack in the evening..."</p> <p>The careplan indicated the following:"... Serve diet as ordered: Regular, Snacks are available to resident between meals upon request, Serve whole milk when milk menued, Monitor weights and intakes, Identified as CACTUS on menu for communicating to staff that resident is a hydration concern, Monitor labs as ordered, Requires adaptive feeding devices of: nosey cups, Requires prompting and or cueing when eating.</p>		<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after</p> <p>each assessment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of Miller's Merry Manor to identify when a resident has experienced variances in their weight and to review and revise the care plan as fluctuations in weights occur. The policy of this facility is to complete weekly weights for the first 4 weeks after admission, then determine the need to continue or discontinue the</p>				

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	<p>During an interview on 9/26/14 at 11:10 A.M., the CDM (Certified Dietary Manager) indicated that residents on a weight loss program should have their interventions updated on the care plan. She further indicated any resident with supplements, snacks, house shakes, or any interventions to increase weight should be updated on the careplan.</p> <p>On 9/29/14 at 9:30 A.M., review of the policy, dated 2/14, provided by the Director of Nursing, titled "... Care Plan Development & Review," indicated but was not limited to the following: "...CARE PLAN REVISION: A. Care plans will be revised daily and PRN as changes in the resident's condition dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin changes etc...."</p> <p>During a second interview with the Certified Dietary Manager on 9/29/14 at 1:10 P.M., the Certified Dietary Manager indicated "... I added him on pudding after weight continued to decrease... should be updated on care plan...."</p> <p>3.1-35(d)(2)(B)</p>		<p>weekly weights at the end of the 4 weeks. If weights are stable, the resident's weights will be reviewed monthly. The facility has reviewed the care plan for resident #95 to ensure that he has appropriate interventions in place to prevent weight loss. Interventions added to #95's care plan included, but are not limited to- Offer HS snack of pudding, straws for liquids, snacks available and offered between meals, Super Cereal at breakfast, 8 ounces of chocolate milk with each meal, and resident requires prompting, cues, and assistance when eating. Resident #95's weights are stable at this time and being monitored on a monthly basis.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents that reside at this facility have the potential to be affected by the alleged deficient practice. All licensed staff and related interdisciplinary staff will be in-serviced on 10/22/2014 by the Director of Nursing and/or her designee on the policy for identifying variances in weights and reviewing and revising the care plans for the residents exhibiting weight fluctuations. Post test related to the identifying residents with weight loss, reviewing, and revising the care</p>				

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			<p>plan will be completed by all licensed nursing staff. The Dietary Manager, Director of Nursing and/or their designees will review the weight summary report, implement any changes, and update the care plans during the weekly weight meetings for all residents exhibiting a weight loss within the past 30 days to ensure that appropriate interventions are in place for these residents. Residents that are on weekly weights will be reviewed to determine if their weights have stabilized. Those that have will be removed from weekly weights list and weights will be monitored monthly.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? *The Dietary Manager, Director of Nursing and/or their designees will complete Quality Assurance audits to ensure that policy and procedures are being followed in relationship to identifying resident with weight variances and that review, and revision of the care plans for those residents is completed. * All licensed staff and dietary managers will be in-serviced on 10/22/2014 by the Director of Nursing and/or her designee on the policy of identifying residents with weight variances and reviewing, and revising the care plans for those residents identified. Post test related to identifying weight</p>	

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			<p>variances and reviewing, and revising the care plan will be completed by all licensed nursing staff and dietary managers. *The dietary manager, Director of Nursing and/or their designees will audit the weight summary report, implement any changes, and update the care plans during the weekly weight meetings for all residents exhibiting a weight loss. *Care Plan will be reviewed and revised at the time of the weekly weight meeting.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Dietary manager, Director of Nursing and/or their designees will complete Quality Assurance Assessments weekly for 4 weeks and then monthly. The Dietary Manager, DON and/or their designees will use the Quality Assurance Tool "Weekly Weight Meeting QA Review" (attachment) to complete these audits. Any related findings will be reviewed with the Quality Assurance committee during the monthly Quality Assurance meeting. RD may be consulted for evaluation of nutritional plan of care.</p> <p>By what date the systemic changes will be completed. The completion</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review the facility failed to ensure care plans were followed related to obtaining resident weights for 1 of 3 residents reviewed for careplans. (Resident #95)</p> <p>Findings include:</p> <p>On 9/25/14 at 3:42 P.M., review of Resident #95 care plan titled " Nutritional risk... at risk for malnutrition..."</p> <p>Interventions indicated "...Monitor weights..." Review of the clinical record at this time for resident #95 indicated the following weights:</p> <p>9/22/2014 07:23 158.8 Manual 9/2/2014 14:59 157.6 Manual 8/24/2014 09:53 156.4 Manual 8/17/2014 12:06 156.4 Standing Manual 8/3/2014 13:38 155.9 Manual 8/1/2014 09:47 158.3 Manual 7/13/2014 13:33 155.6 Manual 7/6/2014 11:44 152.9 Manual 7/3/2014 13:11 155.5 Manual</p>	F000282	<p>date for this Plan of Correction is 10/29/2014.</p> <p><u>F- 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</u></p> <p>-</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Please refer to the Plan of Correction and associated attachments for F- 280.</p>	10/29/2014	

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	<p>6/29/2014 12:52 155.5 Standing Manual 6/22/2014 13:47 154.3 Standing Manual 6/18/2014 19:07 152.4 Manual 6/8/2014 13:44 162.2 Standing Manual 6/3/2014 22:50 164.1</p> <p>On 9/26/14 at 11:10 A.M., review of the policy, dated 7/07, " Weight Management Program" indicated "...4. Residents with continual weight change (loss or gain)... in 30 days will remain on weekly weights until their weight has stabilized...."</p> <p>During an interview on 9/29/14 at 1:10 P.M., the CDM (Certified Dietary Manager) indicated "...if weights are stable then they go to monthly weights... I do not know if Resident #95 is on weekly weights...."</p> <p>During an interview on 9/29/14 at 1:25 P.M., the CDM indicated "... I discontinued weekly weights for resident on 7/11/14 when his weight stabilized...."</p> <p>During an interview on 9/26/14 at 2:26 P.M., LPN #7 indicated "...weekly on Wednesdays at the skins and weights meeting residents with weight loss are discussed... Resident #95 is on weekly weights... we do not document who is talked about in the meetings... if weights are not documented in system, they are</p>			

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F000323 SS=G	<p>not done... Resident #95 should also had weights for the week of 8/10/14, 9/7/14 and 9/14/14...."</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent an accident that resulted in a femur fracture requiring hospitalization and surgical intervention for one of three resident reviewed for accidents. (Resident #26)</p> <p>Finding includes:</p> <p>On 9-24-2014 at 10:25 A.M., Resident #26 was observed in bed. Resident #26 was looking out the window and did not make eye contact when spoken too.</p> <p>On 9-24-2014 at 11:15 A.M., a record review was conducted of Resident #26's chart. Resident #26 was admitted on 6-3-2013, to the locked dementia unit. Diagnoses included but were not limited to, "...vascular dementia with delusions,</p>	F000323	<p><u>F- 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</u></p> <p>-</p> <p>The facility requests a paper IDR for consideration to tag F-323. The outcome of this review requests that the severity of the this tag be reduce from a "G" level to a "D" level or removed from the 2567 entirely based upon supplied documentation and information.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of Miller's Merry Manor to ensure that</p>	10/29/2014			

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	<p>Alzheimer's disease...." The MDS assessment (Minimum Data Set-a assessment tool), dated 5-15-2014, indicated a BIMS (Brief Interview for Mental Status) of 4 out of a possible 15, severe cognitive impairment. Physicians medication orders included, "Aspirin tablet delayed release 81 mg [milligram] Give one tablet by mouth one time a day."</p> <p>The Occurrence Initial Assessment, dated 7-28-2014, indicated "...Date and time of occurrence 07/28/2014 at 0045 [12:45 A.M.]...Fall with injury...CNA [Certified Nursing Assistant] heard resident yelling out, checked on resident and noted her sitting on her floor in her room. Upon entering room writer noted resident sitting on her bottom next to her bed with her legs straight out in front of her. Writer assessed resident and noted abrasions on her right upper calf area and her right ankle. Bright red blood noted to both areas. Resident stated that she slid out of bed and hit her head on her nightstand. Writer noted a slightly raised area 1.5 cm [centimeters] round on her forehead...."</p> <p>The Occurrence Initial Assessment, dated 8-5-2014, indicated "...Date and time of occurrence 08/05/2014 at 0645 [6:45 A.M.]...Fall with no injury...Writer heard</p>		<p>the residents remain free from accident hazards, as is possible and provide adequate supervision and assistance devices to prevent accidents. Resident #26 has been discharged from the facility.</p> <p>-</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents that reside at this facility have the potential to be affected by the alleged deficient practice. There have not been any other residents identified at this time.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The facility reviews the dashboard for clinical alerts related to occurrences/accidents on a daily basis. These occurrences are reviewed during the daily stand up meeting (or Monday if occurrence happened over the weekend), which also serves as the Interdisciplinary Team meeting.. The post fall IDT assessment will be completed at this time.(attachment). Any recommendations from this review will be initiated and implemented and the care plan updated as necessary. An in-service for all</p>	

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	<p>loud thump, upon investigation, Resident noted to be sitting on buttocks on the floor directly in front of her closed door, with legs straight out in front of her. Resident's roommate stated she witnessed fall, that Resident was stepping sideways at end of bed when she lost balance, her back sliding down end of bed, her buttocks hitting floor, ending up with back against closed room door. Roommate and Resident stated Resident did not hit head. Wearing non-skid shoes, call light within reach, but rolling walker across room out of reach...Stated mild tenderness to left knee and mid back. No redness or visible injuries noted at this time...Will request therapy screen and med review with Dr. [Medical Directors name] during rounds this evening...Neuro checks started due to hitting head or unwitnessed fall...NO...."</p> <p>A Progress Note, dated 8-5-2014 at 6:17 P.M., indicated "...Resident was seen today for her continued anxiousness and sleeplessness and falls. medications and treatments reviewed...PT/OT [physical therapy/occupational therapy] eval [evaluation] and treat...."</p> <p>A Progress Note, dated 8-6-2014 at 12:24 P.M., indicated "...OT skilled services for 5x [times] 1 week x4 weeks for ADL [Activities of Daily Living} training,</p>		<p>licensed staff will be held on 10/22/2014 regarding the policy for fall risk management including, but not limited to the completion of the Initial occurrence assessment, reviewing, revising, and implementing interventions or implementing new interventions as soon as possible after the occurrence to ensure the resident safety and needs, and update of the care plan relative to the occurrence, and notification to appropriate parties in regards to the occurrence.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing and/or her designee will complete Quality Assurance Assessments regarding Fall risk Management weekly for 4 weeks and then monthly. The Director of Nursing and/or her designee will use the Quality Assurance Tool "Fall Risk Management Review" (attachment) to complete these audits. Any related findings will be reviewed with the Quality Assurance committee during the monthly Quality Assurance meeting.</p> <p>By what date the systemic changes will be completed. The completion</p>				

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	<p>neuro re-ed [education], there [therapeutic] exercise and there activities...."</p> <p>A Progress Note, date 8-6-2014 at 6 P.M., indicated "...Physical therapy 5 times per week for 4 weeks, for therapeutic exercises therapeutic activities, neuro [neurological]-re-education and gait training...."</p> <p>The Occurrence Initial Assessment, dated 8-7-2014, indicated "...Date and time of occurrence 08/07/2014 at 0445 [4:45 A.M.]...Fall with injury...Writer heard loud bang coming from residents room and immediantly [sic] went to check on resident. Upon entering room writer noted resident lying on her back on the floor near the foot of her bed. Resident was not incontinent and was wearing gripper socks. Floor was dry and free of debris. Residents right leg was rotated outward. Resident was stating extreme pain when right hip area was touched. No swelling noted to area. No further injuries noted. NW [North West] nurses placed resident on sliding board and onto her bed. Writer phoned physician and received order to send resident to [name of local hospital] ER [emergency room] for evaluation and treatment per ambulance...."</p>		date for this Plan of Correction is 10/29/2014.				

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	<p>On 9-29-2014 at 12 P.M., an interview was conducted with LPN #4. LPN #4 indicated, "...She [Resident #26] was admitted to Country Meadows [locked dementia unit] in 2013. She fell there and went to the hospital on 8-7-2014 with a hip fracture, she had surgery to fix it and was readmitted on 8-14-2014 to the facility on a different unit because she needed more assistance...."</p> <p>On 9-29-2014 at 1 P.M., record review of Resident #26's care plans was conducted. Fall risk care plan, dated 6-5-2013, indicated, "...Fall Risk characterized by risk factors decreased safety awareness due to Alz [Alzheimer's] Dementia, History of fall with fracture to lower arm...Interventions...Encourage resident to use handrails or assistive devices properly [created on 6-5-2013]...Reassess fall risk factors at least quarterly [created 6-5-2013]...Monitor for changes in gait/positioning [created on 6-5-2013]...Call light within reach. Explain use of it upon admission and reinforce as needed. [created on 6-5-2013]...Encourage and assist with wearing non-skid foot-wear before getting out of bed. [created on 4-22-2014]...Non-skid strip on the floor next to the bed. [created on 7-30-2014]...."</p>						

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	<p>On 9-29-2014 at 1:15 P.M., review of the "Incident/Accident Report Procedure & Form" dated 12-6-2013, received on 9-26-2014 at 11:30 A.M., from the DON (Director of Nursing), indicated "...3. PROCEDURE:...A. ASSESSMENT AND INVESTIGATION:...V. If there is any evidence of fracture or severe head trauma, do not move resident until emergency services arrive...VII. If the fall was not witnessed and the resident is unable to accurately inform staff that they did not hit their head, begin neurological assessment. Assess neurological system during assessment of injuries for all un-witnessed falls...C. DOCUMENTATION REQUIREMENTS:...II. Complete the fall assessment at the bottom of the "occurrence initial" assessment if the patient had a fall...."</p> <p>On 9-29-2014 at 3:30 P.M., during an interview, the DON (Director of Nursing) indicated, "... it would not be appropriate for a resident with a BIMS of 4 to have an intervention on their care plan that would be a reminder to use their call light...I should have checked the incident with an IDT [Interdisciplinary Team] form that I am supposed to be filling out...I did not know I was supposed to and none has been filled out since this spring...."</p>						

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F000325 SS=D	<p>There was no documentation to indicate the care plans were updated to include increased supervision or other interventions to prevent falls.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview, and record review, the facility failed to prevent weight loss for 1 of 3 sampled residents who met the criteria for weight loss since admission. (Resident #95)</p> <p>Finding includes: On 9/25/14 at 3:42 P.M., review of the clinical record for Resident # 95 indicated diagnoses, include but not limited to, "...Dementia unspecified with behavioral disturbance, vascular Dementia with delusions, depressive disorder, constipation, pure hypercholesteolemia, urinary</p>	F000325	<p><u>F – 325 Maintain Nutrition Status Unless Unavoidable</u></p> <p>-</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of Miller's Merry Manor to maintain acceptable parameters of nutritional status such as body weight for residents whose clinical condition meets the criteria. Resident #95 is receiving an appropriate diet as determined by the facility dietician to maintain acceptable parameters of nutritional status. At this time</p>	10/29/2014

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	<p>incontinence.</p> <p>Resident #95 weight's indicated that his admission weight on 6/03/14 was 164 pounds and on 9/28/14 was 148 pounds, indicating a weight loss of 9.73%.</p> <p>There was no documentation for weight orders on the physician's orders.</p> <p>The nutrition care plan, dated 6/30/14, indicated "...indicates at risk for malnutrition, difficulty of feeding self, has poor vision, does not drink a minimum of 1500 ml fluids daily, abnormal labs, cognitive Impairment...resident will remain free from significant weight loss of 5% in 1 month, 7.5% in 3 months, and 10% in 6 months thru next review date...."</p> <p>A dietary note, dated 6/10/2014, indicated "...Recommendation: Changes are recommended. Suggest CDM [Certified Dietary Manager] to work with res/family to find protein rich foods that resident may eat to try and meet minimum protein needs and also increase calories. Review of dietary note dated 6/10/12 indicated "... at risk for malnutrition....noted to have low albumin... resident does not eat/drink well...."</p>		<p>resident #95 is maintaining an acceptable nutritional status for body weight.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents that reside at this facility have the potential to be affected by the alleged deficient practice. There have not been any other residents identified at this time.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? All new residents will be put on weekly weights for at least 4 weeks in order for the facility to determine a baseline weight for this resident. The facility will then determine through the weekly weight meetings whether this resident's weight is stable and if so, the facility will discontinue the weekly weight program and continue monitoring with monthly weights. If the facility determines that the resident's weight is still unstable after the first 4 weeks the facility will continue with weekly weights as needed and continue to implement interventions to maintain acceptable parameters of nutritional status.</p>		

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	<p>A dietary note, dated 6/27/2014, indicated "...weight concern...152.4, vital date: 2014-06-18, -3.0% change from last weight... will add whole milk to meals...."</p> <p>A dietary note, dated 7/11/2014, indicated "...weight concern...152.9, vital date: 2014-07-06, -5.0% change over 30 days...Resident's weight has decreased...He currently has a regular diet. Will add pudding snack in the evening...."</p> <p>Lab results, dated 8/4/2014, indicated "...received lab abnormal results...HGB [hemoglobin] 13.0 low, HMC [Hematocrit] 38.4 low, Protein 6.2 low, Albumin 3.3 low...."</p> <p>On 9/26/14 at 11:10 A.M., review of the policy, dated 7/07, " Weight Management Program" indicated "...4. Residents with continual weight change (loss or gain)... in 30 days will remain on weekly weights until their weight has stabilized...."</p> <p>During an interview on 9/29/14 at 1:10 P.M., the CDM (Certified Dietary Manager) indicated "...if weights are stable then they go to monthly weights... I do not know if Resident #95 is on weekly weights...."</p> <p>During an interview on 9/26/14 at 2:26 P.M., LPN #7 indicated "...weekly on Wednesdays at the skins and weights</p>		<p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Dietary manager, Director of Nursing and/or their designees will complete Quality Assurance Assessments weekly for 4 weeks and then monthly. The Dietary Manager, DON and/or their designees will use the Quality Assurance Tool "Weekly Weight Meeting QA Review" (Attachment # 5) to complete these audits. Any related findings will be reviewed with the Quality Assurance committee during the monthly Quality Assurance meeting.</p> <p>By what date the systemic changes will be completed. The completion date for this Plan of Correction is 10/29/2014.</p>	

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F000364 SS=F	<p>meeting residents with weight loss are discussed... Resident #95 is on weekly weights... we do not document who is talked about in the meetings... if weights are not documented in system, they are not done...."</p> <p>During an interview on 9/29/14 at 1:25 P.M., the CDM indicated "... I discontinued weekly weights for resident on 7/11/14 when his weight stabilized.... "</p> <p>During an interview on 9/26/14 at 2:26 P.M., LPN #7 indicated "...weekly on Wednesdays at the skins and weights meeting residents with weight loss are discussed... Resident #95 is on weekly weights... we do not document who is talked about in the meetings... if weights are not documented in system, they are not done...."</p> <p>On 9/29/14 at 2:45 P.M., a review of the CNA weekly weight sheet, dated 9/28/14, indicated Resident #95 weight was 148.2...."</p> <p>3.1-46(a)(1)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility</p>						

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	<p>provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to ensure food was served at the proper temperatures. This had the potential to affect 85 of 85 residents that received meals from 1 of 1 kitchen.</p> <p>Finding includes:</p> <p>During an interview on 9/23/14 at 2:38 P.M., Resident # 45 indicated that "... the food is cold and the trays are served late...."</p> <p>During an interview on 9/24/14 at 10:21 A.M., Resident #19 indicated that "... sometimes when my food gets to the table it's cold...."</p> <p>During an interview on 9/24/14 at 1:46 P.M., Resident #40 indicated that " when I get my breakfast the eggs are cold and the food all runs together...."</p> <p>On 9/29/14 at 8:15 A.M., the temperature of a breakfast plate being served from the kitchen to the main dinning room was checked by Employee #6 and found the temperature of the sliced ham was 113 degrees Fahrenheit (F).</p> <p>On 9/29/14 at 8:50 A.M., a room tray</p>	F000364	<p><u>F – 364 Nutritive Valud/Appearance. Palatable/Prefer Temp</u></p> <p>-</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>-</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of Miller’s Merry Manor to provide foods that have nutritive value, flavor, a good appearance and be at the proper temperature. Following the facilities policies and procedures the dietary staff will monitor and check the food temperatures as appropriate before each meal service and ensure that the food temperatures are within appropriate ranges as determined by the policy and record these temperatures on the “Food Temperature Log” sheet (Attachment 7).</p>	10/29/2014	

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	<p>was temped in the Northwest dining room by Employee #6 and found the temperature of the sliced ham was 113 degrees (F). Employee #6 at this time indicated "... that hot food should be served at 135 degrees (F) or greater, 113 degrees is not hot enough...."</p> <p>On 9/29/14 at 9:00 A.M., an observation of Resident #40 room tray found that the resident's meal plate had no warming plate under it. An interview with Resident #40 indicated that "... I haven't had a warming plate under my meals all weekend...."</p> <p>During an interview on 9/29/14 at 9:05 A.M., the CDM (Certified Dietary Manager) indicated that "...we try to put a warming plate under all room trays to help with the temperature. We only have 10 warming and sometimes that not enough for under all plates if we have more than 10 room trays... today we only had 7 room trays so all breakfast plates should have had a warming plate under them...."</p> <p>3.1-21 (a)(2)</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents that reside at this facility have the potential to be affected by the alleged deficient practice. There have not been any other residents identified at this time.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Daily the staff will measure the temperature of all food items according to the facilities policy and procedure manual and record this data on the food temperature log (Attachment 7). The facility Dietary Manager will in-service all dietary staff on the proper technique and procedure to measure and maintain food temperatures before, during and after meal service on 10/22/14. Staff will also be in serviced on the proper use of the hot pallets for all room trays in order to assist in maintaining proper food temperatures.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility Dietary Manager will</p>	

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure that food was served under sanitary conditions for one of 3 dining rooms observed. The facility further failed to ensure food and dishes were stored under sanitary conditions; and, food	F000371	complete a Test Tray Audit daily for 30 days, weekly for 2 months and then monthly (Attachment 6). The Dietary Manager will also complete the QA audit tool "SBOH 2014 Plan of Correction Checklist" (Attachment 8) monitoring food temp logs to ensure that all logs are completed fully and if temperatures are measured within the appropriate range what corrective action was taken to restore the proper temperature. By what date the systemic changes will be completed. The completion date for this Plan of Correction is 10/29/2014. <u>F – 371 Food Procure, Store/Prepare/Service – Sanitary</u> - The facility must – Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary	10/29/2014	

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	<p>temperature logs were maintained, for one of one kitchens.</p> <p>Findings include:</p> <p>1. On 9-29-2014 at 7:44 A.M., LPN #4 (Unit Manager for Central Hall) was observed serving a resident a bowl of oatmeal with her thumb in the bowl.</p> <p>On 9-29-2014 at 7:45 A.M., CNA (Certified Nursing Assistant) #3 was observed holding the hand of a resident and walking him to his table in the main dining room. CNA #3 then picked up a clothing protector off the resident's table and 3 other clothing protectors fell on to the floor. CNA #3 then picked up the 3 clothing protectors off the floor and placed them into a barrel for dirty linens. CNA #3 then placed a clothing protector on to the resident. CNA #3 went into the activity closet located in the main dining and brought 3 more clothing protectors out and placed them on the resident table. CNA #3 was observed bringing another resident in his wheelchair into the dining room. CNA #3 went back in to the activity closet and put a serving apron on and then started to serve drinks to residents off the drink cart. CNA #3 was not observed to wash her hands or use hand sanitizing gel.</p>		<p>conditions.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? LPN #4 and CNA #2 will be reeducated on dining room service techniques on 10/22/14. All staff will be in-serviced on 10/22/14 on food handling in regards to serving plates, bowls, and glasses as well as hand washing and hand asepsis. All dietary staff will be in-serviced on 10/22/14 and reeducated on the need to document and take food temperatures before every meal. All food storage areas have been inspected (dry storage room, walk-in refrigerator and freezer) and all food items have been labeled and dated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents that reside at this facility have the potential to be affected by the alleged deficient practice. There have not been any other residents identified at this time.</p> <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Food Temperature logs will be completed by the appropriate</p>		

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	<p>On 9-29-2014 at 7:56 A.M., CNA #2 was observed serving drinks to residents during breakfast in the main dining room. CNA #2 was picking up resident glasses by the rim with her palm over the opening to the glass before filling them.</p> <p>On 9-29-2014 at 12:09 P.M., review of the current policy, dated 1-30-2013, " Food Preparation, Food Handling, and Service" provided by the Administrator indicated, "... 2. Procedure: V... not touching rims of glassware, eating surfaces of plates, bowls, and cups...."</p> <p>On 9-29-2014 at 6:15 P.M., the DON (Director of Nursing) indicated during an interview, "...employees should pick up plates from the bottom, they [employees] should not touch the rims of glasses...my expectation would be that employees would wash their hands between resident contact and before serving residents in the dining room...."</p> <p>On 9-29-2014 at 6:40 P.M., record review of the current policy, dated 07-27-2012, "Hand Washing and Hand Asepsis" provided by the Administrator indicated, "5...Hands should be washed with soap and water during meal service if there is direct hands-on contact with residents ie. [example] Adjusting positioning, touching the residents face,</p>		<p>dietary staff before each meal service. All staff will also be in-serviced on the facility hand washing policy and procedure and will demonstrate the proper techniques to wash hands. The facility will also in-service the staff on the proper techniques to carry items like bowls, plates and cups and a diagram (attachment 9) describing the proper technique will be given out at this in-service and posted in the dining room for all staff to review. All food storage areas have been inspected and all items are labeled and dated. All dietary staff will be reeducated on the food storage, labeling and dating policy and the procedure for general storage of dishes and other items in the kitchen.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The food temperature logs will be reviewed daily by the Dietary Manager for 30 days, then weekly for 2 months and then monthly. The Dietary Manager will complete the "SBOH 2014 Plan of Correction Checklist" (Attachment 8) during the time frame specified above. Any findings will be corrected immediately and reported to the monthly QA meeting. All staff will be in-serviced on the proper techniques to handle plates,</p>				

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	<p>etc...."</p> <p>2. On 9/23/14 between 11:05 A.M. and 11:45 A.M., during the initial kitchen tour with the CDM (Certified Dietary Manager) the following was observed:</p> <p>In the Dry storage room:</p> <ul style="list-style-type: none"> *1 large box of onions without a date. *1 large box of sweet potatoes without a date. * The CDM indicated at this time that "...they should have a date on them" <p>In the walk in cooler:</p> <ul style="list-style-type: none"> *one 5 pound package of sliced American cheese open with no date. *37 bowls of tapioca pudding covered with plastic wrap with no date. *8 bowls of Jello covered with plastic wrap with no date. *31 single serving cups of ketchup covered with plastic wrap and no date. *15 single serving cups of mustard covered with plastic wrap with no date. *The CDM indicated at this time that "...any food that has been open should have a open date on it" <p>In the walk in freezer:</p> <ul style="list-style-type: none"> *a open plastic bag containing 7 chicken breasts with no date on it. *1 open bag of oyster crackers with no date. * 8 frozen hamburger patties in plastic 		<p>bowls, glasses and other dishware and will be provided with a handout depicting the proper techniques to do so (Attachment 9). All dietary staff will be in-serviced on the procedure for storing items in the kitchen, labeling and dating food items, and this will be monitored by the Dietary Manager with the "SBOH 2014 Plan of Correction Checklist" (Attachment 8).</p> <p>By what date the systemic changes will be completed. The completion date for this Plan of Correction is 10/29/2014.</p>	

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	<p>bag, undated and open to air.</p> <p>*The CDM indicated at this time that "...the bag should be closed and dated...."</p> <p>*11 English muffins in plastic bag with no date.</p> <p>*8 donuts on paper plate, dated 8/20/14.</p> <p>*The CDM indicated at this time that "...items in freezers should only be kept 30 days after opening... these should be disposed of"</p> <p>In the dishwasher area:</p> <p>*14 coffee cup saucers stored up right on cart.</p> <p>*12 drink pitcher lids stored upright</p> <p>*10 plastic cups stored on there side on the clean dish rack.</p> <p>*The CDM indicated at this time " ... they should be stored upside down...."</p> <p>Under the prep counter:</p> <p>*3 cooking pans, 1 colander, 5 nested mixing bowls stored upright.</p> <p>Reach in freezer:</p> <p>*30 small bowls of chocolate ice cream and 17 small bowls of mint chocolate chip ice cream covered with plastic wrap with no date on them, one 3 gallon container of black cherry ice cream, two 3 gallon container of mint chocolate chip ice cream, one 3 gallon container of caramel crunch ice cream, one 3 gallon container of chocolate chunk ice cream,</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>open with no open date on them. The CDM indicated at this time "... yes they all should be dated...."</p> <p>During an interview on 9/26/14 at 10:30 A.M., the CDM indicated "... they do not have a policy on how clean dishes are to be stored on the shelves...."</p> <p>On 9/26/14 at 11:10 A.M., review of the current, undated, policy titled " Food Protection and Storage" provided by the CDM indicated " ... 1.... G. Open boxes, containers of food are securely enclosed, labeled , and dated.... P... Planned left over food is stored in covered containers or wrapped carefully and securely, clearly marked and dated.... 2... O. Stock in freezer is wrapped in air tight containers, labeled and dated...."</p> <p>3. On 9/29/14 at 8:45 A.M., review of the food temperature logs provided by Employee #6 found no food temperatures documented for breakfast on September 26th, 27th, or 28th, 2014 and no food temperatures documented for supper on September 27th or 28th, or lunch on September 28th, 2014.</p> <p>During an interview on 9/29/14 at 1:10 P.M., the CDM (Certified Dietary Manager) indicated " ... the cook is responsible for taking food temps and</p>						

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	<p>documenting it on the Breakfast, Lunch, Supper food temperature logs...."</p> <p>On 9/29/14 at 12:09 P.M., review of the policy, dated 8/20/12, " Food and Beverage Temperature Testing" provided by the Administrator indicated "... 2... A Food Temperature Record Log ... is to be completed prior to meal service by the morning and afternoon cooks...."</p> <p>3.1-21(i)(2)</p>				