

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155768	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/23/2015
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NAME OF PROVIDER OR SUPPLIER  EVANSVILLE PROTESTANT HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WASHINGTON AVE EVANSVILLE, IN 47714
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 11, 12, 17, 18, 19, &amp; 23, 2015</p> <p>Facility number: 001125 Provider number: 155768 AIM number: pending</p> <p>Survey Team: Anna Villain, RN-TC Denise Schwandner, RN Barbara Fowler, RN Diana Perry, RN, (2/11, 2/12, 2/17, 2/19, &amp; 2/23, 2015</p> <p>Census bed type: SNF: 17 SNF/NF: 22 Residential: 62 NCC: 15 Total: 116</p> <p>Census payor type: Medicare: 11 Medicaid: 1 Other: 42 Total: 54</p>	F000000	Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of regulatory required response and is not to be construed as agreement with the deficiencies cited.	

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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F000282 SS=D	<p>Residential sample: 7 NCC sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on February 25, 2015 by Jodi Meyer RN</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow the written care plan, in that, alarms and non-slip socks were not placed for 1 of 2 residents reviewed for falls in a sample of 2 who met the criteria. (Resident #75)</p> <p>Findings include:</p> <p>On 2/18/15 at 8:32 a.m., Resident #75's clinical record was reviewed. Resident #75's diagnoses included, but were not limited to, prostate cancer, encephalopathy, and falls.</p>	F000282	<p><b><u>F-282 Services provided by qualified persons per Care Plan</u></b> <b>What corrective action will be accomplished for resident found to be affected by deficient practice?</b> Resident #75 passed on 2-22-15, with family and hospice at bed side. Resident #75 was evaluated for inpatient hospice services on two different occasions, per facility request due to a rapid decline in health, and not found to be appropriate for inpatient placement. The plan of care was continuously updated to meet the resident's needs. <b>How other residents potentially affected</b></p>	03/25/2015

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	<p>The most recent admission MDS (Minimum Data Set) Assessment, dated 1/20/15, indicated the resident had fallen prior to admission and the resident had fallen since admission</p> <p>The care plans included, but were not limited to: Resident at risk for falling related to decreased mobility. The interventions included, but were not limited to, gripper socks when in bed at all times and equip resident with device that monitors rising, bed and chair pad alarms.</p> <p>The nursing notes included, but were not limited to: On 1/19/15 at 7:30 p.m., the resident required bed and chair alarms due to decreased safety awareness On 1/20/15 at 6:45 a.m., the resident was found on the floor. The note lacked documentation regarding alarms sounding. On 1/26/15 at 8:30 a.m., resident's alarm was sounding, resident lying on the bathroom floor, and the fall intervention would be to place non slip socks on the resident while in bed. On 2/13/15 at 4:20 p.m., resident alarm was sounding, resident lying on back with head towards the foot of the bed, resident noted to have no socks on.</p>		<p><b>will be identified and corrective actions taken?</b> All residents are potentially affected by the cited deficiency. The Director of Nursing or designee shall review written care plans for appropriate interventions and their utilization. Assignment sheets are available to all nursing staff and shall be reviewed for intervention communication. . Changes in the plan of care will be added by the MDS coordinator or designee as interventions change in congruence with orders and applicable care. Assignment sheets shall be updated by the Unit Manager or designee as interventions change. 3) <b>What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b> To enhance currently complaint operations, under the direction of the Director of Nursing, all licensed nursing staff will receive in-service training regarding state and federal requirements of the plan of care. The in-service training will include how each care plan must reflect the resident's orders, and daily direct care needs. The in-service will also include location of the care plan in the medical record,problem identification, intervention utilization, and have a focus on the expected outcomes of care planning. Staff will be instructed on the need to follow the interventions for all care plans</p>				

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	<p>On 2/18/15 10:32 a.m., LPN #1 indicated alarms were instituted since admission for Resident #75. LPN #1 indicated she could not locate documentation regarding whether Resident #75's alarms were sounding after his fall on 1/20/15. LPN #1 further indicated after Resident #75 fell on 1/26/15, the nursing staff instituted gripper socks to be placed on Resident #75 while he was in bed.</p> <p>On 2/18/15 at 1:20 p.m., 2/18/15 at 11:13 a.m., and 2/19/15 at 8:27 a.m., Resident #75 was observed to have his alarms in place and was wearing the proper footwear.</p> <p>On 2/23/15 at 2:54 p.m., the Administrator provided the Comprehensive Care Plans policy, dated 2010. The policy included, but was not limited to, "Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying sources of the problem areas, rather than addressing only symptoms or triggers."</p> <p>3.1-35(g)(2)</p>		<p>with specific focus on at risk residents. All nursing staff shall receive in-service regarding the importance of intervention utilization for effective care delivery. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> Effective 3-23-15 a Quality Assurance program was implemented to ensure continued care plan intervention utilization audits are conducted and reviewed by interdisciplinary team. The MDS coordinator and/or designee will audit resident specific care plan interventions for congruence with physician orders and actual daily care. The MDS coordinator and/or designee will perform random audits of nurse knowledge by interview of resident care plan interventions. All audits will be completed 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, one time weekly for 4 weeks and then monthly. Any variation in regulatory guidelines will be corrected immediately. All audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless the QA committee deems 100% compliance was achieved. <b>What date systemic changes will be completed?</b> Completion date 3-25-15</p>		

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F000309 SS=D	<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 provide necessary care and treatment for 1 of 2 residents reviewed, who spent long intervals of time in bed and were prone to physical discomfort. (Resident #77)</p> <p>Findings include:</p> <p>During an observation on 2/12/15 at 10:00 a.m., Resident #77 was observed to be lying on his back in bed. Resident #77 had scabbed areas on bilateral elbows and had dressings to both elbow. Resident #77 indicated he had fallen at home and obtained the abrasions prior to being admitted to the facility.</p> <p>During an observation on 2/17/15 at 2:34 p.m., Resident #77 was observed to be lying on his left side in bed. Resident #77 indicated he did not like to lie on his</p>	F000309	<p><b><u>F-309 Provide care or services for highest well being What corrective action will be accomplished for resident found to be affected by deficient practice? Resident #77 discharged from the facility, to independent living, with home health on 2-21-15. The resident was provided an additional gel overlay mattress for comfort on 2-19-15. The nurse who charted the request was counseled regarding appropriate communication of resident request. The facility's nursing mattresses were replaced three years ago with pressure reduction surfaces by Panacea via Direct Supply. Each resident, at a minimum, utilizes a pressure reduction mattress upon admission. How other residents potentially affected will be identified and corrective actions taken? The facility's nursing mattresses were replaced over the last five years with</u></b></p>	03/25/2015

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	<p>sides in bed and the facility was supposed to be getting him a new mattress to help his back soreness. The resident was able to turn side to side per self.</p> <p>During an observation on 2/18/15 at 8:30 a.m., Resident #77 was observed to be lying in bed on his back. The resident's skin condition was observed at that time. His sacral area and the back of his left rib cage areas were red but blanchable.</p> <p>The clinical record for Resident #77 was reviewed on 2/16/15 at 4:08 p.m. Resident #77 had diagnoses including, but no limited to, cirrhosis of the liver with ascites, and esophageal reflux. The admission MDS (Minimum Data Set) assessment, dated 2/14/15, indicated Resident #77 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident had no cognitive impairment. The MDS further indicated Resident #77 was at risk for pressure wounds.</p> <p>A nurse's note, dated 2/13/15 at 1930 (7:30 p.m.), indicated Resident #77 had no complaints of discomfort other than the mattress was uncomfortable on his buttocks. The nurse's note indicated the resident was uncomfortable lying on his side. The nurse's note further indicated a note was left on the calendar to obtain a</p>		<p>pressure reduction surfaces via Direct Supply. Each resident, at a minimum, utilizes a pressure reduction mattress upon admission. All residents have the potential to be affected by the cited deficiency. The Director of Nursing or designee shall complete audit of residents who spend long periods of time in bed and are prone to discomfort. The audit shall consist of resident interview and review of MDS assessment regarding bed mobility and skin areas. All residents found to have a desire for a different mattress surface, unless contraindicated, or physical need for additional surfaces were corrected immediately. <b>What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b> To enhance currently complaint operations, under the direction of the Director of Nursing or designee licensed staff shall receive in-servicing regarding utilization of additional mattress surfaces for residents who spend long periods of time in bed or are prone to discomfort. Mattress change request shall be completed individually as needed or placed on a work order and forwarded to environmental services for completion and tracking purposes. <b>How the corrective actions will be monitored to ensure the deficient practice will not</b></p>				

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F000311 SS=D	<p>gel overlay for the mattress and encouraged the resident to turn.</p> <p>During an interview on 2/17/14 at 3:15 p.m., the DON (Director of Nursing) indicated the facility had gel overlays for the mattresses in the basement. The DON indicated she did not know the reason the staff had not obtained a gel overlay for the resident's bed.</p> <p>During an interview on 2/17/15 at 2:50 p.m., LPN #4 indicated she had not received the request until yesterday and she had not had time to obtain the gel overlay yet. LPN #4 indicated the resident's skin is fine.</p> <p>3.1-37(a)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a functional maintenance program was followed and/or provided as instructed by recommendations from</p>	F000311	<p><b>recur?</b> In addition to the routine review of work orders by environmental services, duplicate copy of the work order shall be forwarded to Administrator for follow up on completion. Random resident interview of mattress comfort due to desire or nurse assessment of physical need shall be monitored 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for four weeks, and then monthly for 3 months to ensure residents who spend long intervals of time in bed and are prone to discomfort receive appropriate mattress surface. Any variation in protocol or processing will result in immediate correction. Audits shall be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless QA committee deems 100% compliance was achieved. Completion date: 3-25-15</p> <p><b><u>F 311Treatment/Services to Improve/maintain ADLS</u></b> <b>What corrective action will be accomplished for resident found to beaffected by deficient practice?</b> Resident #49 was started on</p>	03/25/2015			

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	<p>physical/occupational therapy for 1 of 2 residents reviewed for falls. (Resident #49)</p> <p>Findings include:</p> <p>During an observation on 2/17/15 at 8:05 a.m., Resident #49 was observed to be ambulating to the dining room with CNA #1. Resident #49 was observed to be wearing a gait belt and was ambulating with a walker.</p> <p>The clinical record of Resident #49 was reviewed on 2/16/15 at 4:54 p.m. Resident #49 was admitted to the skilled nursing unit on 1/2/15. Resident #49 had diagnoses including, but not limited to, diabetes mellitus type 2, insomnia, atrial fibrillation, hypertension, and benign prostatic hypertrophy. An admission MDS (Minimum Data Set) assessment, dated 1/11/15, indicated Resident #49 had moderate cognitive impairment. The MDS indicated Resident #49 required extensive assistant of 1 person for transfers and limited assistance of 1 person for ambulation. The MDS further indicated Resident #49 had received physical therapy and occupational therapy services.</p> <p>Resident #49 had a care plan, dated 1/19/15, which indicated PT (physical</p>		<p>adocumented restorative program. Resident #49 has suffered no ill effects, participates in daily unit exercise program and walks to dining room for all meals. Resident #49 participates in other activities of interest which require physical movement and are helpful to maintain physical function.</p> <p><b>What corrective action will be accomplished for resident found to be affected by deficient practice?</b></p> <p>All residents have the potential to be affected by the cited deficiency. The Director of Nursing or designee shall audit all residents discharged from therapy in last 30 days for an initiated functional maintenance program. Residents identified with a written functional maintenance program on the chart but not in place shall be implemented immediately.</p> <p><b>What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b></p> <p>To enhance currently complaint operations, under the direction of the Director of Nursing or designee nursing staff shall receive in-servicing regarding implementation of functional maintenance programs as instructed by therapy.</p>				

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	<p>therapy)/OT(occupational therapy) recommendations were to be followed.</p> <p>Resident #49 had a physician's order, dated 1/30/15 at 0800 (8:00 a.m.), indicating "D/C (discontinue) skilled PT (physical therapy) services secondary to pt (patient) has met maximum potential. RT (restorative therapy) program established."</p> <p>Resident #49 had a physician's order, dated 1/30/15 at 1500 (3:00 p.m.), indicating "D/C skilled OT (occupational therapy) services secondary pt. has met max (maximum) rehab (rehabilitation) potential partially delivering goals. BUE (bilateral upper extremities RT program established and issued."</p> <p>The clinical record indicated Resident #49 had the physical therapy "Restorative Nursing Program" recommendations, with the effective date of 1/31/15, as followed:</p> <ol style="list-style-type: none"> <li>1. Encourage resident to participate in the daily exercises in the dining room.</li> <li>2. Walk bid (2 times per day) with 4 wheel walker approximately 200 feet.</li> </ol> <p>The clinical record indicated Resident #49 had the occupational therapy "Restorative Nursing Program" recommendations with the effective date</p>		<p>In-service shall includecommunication of functional maintenance program implementation when dischargedfrom therapy, documentation of a functional maintenance program, and referralsto therapy for noted physical decline not related to an acute event.</p> <p><b>How the corrective actions willbe monitored to ensure the deficient practice will not recur?</b></p> <p>In addition to the verbalreview at weekly Medicare meeting for functional maintenance program recommendations,a copy of therapy discharges which reference a functional maintenance programshall be provided to the Director of Nursing or designee for review and followup. Therapy discharges shall be monitored for functional maintenance programs5times a week for 4 weeks, 3 times a week for 4 weeks, weekly for four weeks,and then monthly for 3 months to ensure residents who discharge from therapyhave functional maintenance programs implemented as recommended. Any variationin protocol or processing will result in immediate correction. Audits shall besubmitted to the Quality Assurance Committee for review and/or furthercorrective action. Audits will not titrate down unless QA committee deems</p>	

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	<p>of 1/31/15, as followed:</p> <ol style="list-style-type: none"> <li>1. Encourage resident to participate with facility's daily exercise group and facility activities</li> <li>2. Complete red theraband (a type of stretchy band used for exercising the extremities) exercises as tolerated; refer to handout for details. A separate document with pictures of the exercises were with the recommendation.</li> </ol> <p>During an interview on 2/17/15 at 2:24 p.m., LPN #4 indicated Resident #49 did not have a form to document his restorative program yet. LPN #4 indicated walking the resident to the dining room was the recommendation for the restorative program and the CNA's performed the task daily.</p> <p>During an interview on 2/17/15 at 2:50 p.m., the MDS (Minimum Data Set) assistant, the MDS Coordinator, and the ADON (Assistant Director of Nursing) indicated Resident #49 was not on a restorative program. The ADON indicated when a resident is discharged from therapy, the resident is given exercises to do in their apartment and the resident had previously resided in an apartment prior to transferring to the skilled unit. The ADON indicated the facility should have been doing the restorative nursing program on the skilled</p>		<p>100%compliance was achieved.</p> <p>Completion date: 3-25-15</p> <p>-</p>				

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F000329 SS=D	<p>unit as per the physician's orders. The MDS Coordinator indicated Resident #49 did attend group exercises in the dining room but Resident #49 had not received any restorative nursing program since being discharged from therapy.</p> <p>A policy titled, "Restorative Nursing Care," dated 4/2013, and obtained from the Administrator on 2/23/15 at 2:30 p.m., indicated rehabilitative nursing care is provided for each resident admitted.</p> <p>A policy titled, "Goals and Objectives, Restorative Services," dated 4/2014 and obtained from the Administrator on 2/23/15 at 2:30 p.m., indicated "rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services."</p> <p>3.1-38(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>			

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	<p>combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure blood pressure was monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident #11)</p> <p>Findings include:</p> <p>The clinical record of Resident #11 was reviewed on 02/17/2015 at 10:12 a.m. The record indicated the diagnoses included, but were not limited to, depression, coronary artery disease, anemia, dementia, congestive heart failure, chronic renal disease, and arthritis.</p> <p>The Physicians Orders for Resident #11 indicated Lisinopril (antihypertensive medication) 10 mg (milligrams) 1 tablet at bedtime. Please hold if SBP (systolic blood pressure) &lt; (less than) 120.</p>	F000329	<p><b><u>F 329 Drug Regimen is free from unnecessary drugs</u> What corrective action will be accomplished for resident found to be affected by deficient practice?</b> Resident #11 has suffered no ill effects. Blood pressure monitoring entry line is currently transcribed to MAR. Physician and family have been notified. No new orders have been received. <b>What corrective action will be accomplished for resident found to be affected by deficient practice?</b> All residents have the potential to be affected by the cited deficiency. The Director of Nursing or designee shall audit all residents receiving blood pressure medication for transcription of blood pressure monitoring to the MAR. Residents identified with orders for blood pressure monitoring shall be implemented immediately. <b>What measures will be put in place or systemic</b></p>	03/25/2015			

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F000465 SS=E	<p>The medical record failed to have documentation of blood pressure monitoring.</p> <p>An interview with LPN #2 on 02/17/2015 at 10:33 a.m., indicated Resident #11 did not get daily blood pressure checks.</p> <p>3.1-48(a)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p>		<p><b>changes made to ensure the deficient practice does not recur?</b> To enhance currently complaint operations, under the direction of the Director of Nursing or designee, licensed nurse staff and QMA's shall receive in-servicing regarding blood pressure monitoring and parameter order transcription to the MAR. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> In addition to admission order review practice of 2 nurse signatures, rewrites (one month of orders which flow to the next month of orders) shall also be reviewed by 2 nurses for residents who require blood pressure monitoring. Management shall monitor for completion of 2 nurse review practices 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for four weeks, and then monthly for 3 months to ensure residents with blood pressure monitoring orders are implemented. Variation in protocol or processing will result in immediate correction. Audits shall be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless QA committee deems 100% compliance was achieved. Completion date: 3-25-15</p>		

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	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for facility staff, resident, and families, in that, dirt and debris were built up around the cove base and in corners of the rooms, closet doors had holes in them, door frames were marred and scuffed, sink drains had stains around them, rooms had chipped paint and missing dry wall, and rooms had screw holes in them. This affected 5 of 23 rooms observed during stage 1. (Room #3, #4, #7, 10, #26)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an observation on 2/12/15 at 10:42 a.m., Room #3 was observed to have dirt built up around the edges of the cove base and in the corners of the room and bathroom, the bathroom door frame was marred and the bathroom sink had a brownish-yellow stain around the drain. The same was observed on 2/18/15 at 8:43 a.m. Screw holes were observed to be located below the towel bar at that time.</li> <li>2. During an observation on 2/12/15 at</li> </ol>	F000465	<p><b><u>F465 Safe/Functional Sanitary Comfortable Environment</u> What corrective action will be accomplished for resident found to be effected by deficient practice?</b> Residents have suffered no ill effects. Residents nor families have voiced concern or dissatisfaction regarding a sanitary environment. Room #3 shall have dirt and debris build up cleaned from the corners of room and bathroom. Room #4 shall have the hole in the door repaired or replaced entirely. Room #7 shall have the room and door frame painted, the sink has been cleaned and the brown stain removed. Room #10 has had nail holes repaired in the wall and the bathroom drain cleaned. Room#26 has had the room cleaned, the trash can emptied and the toilet paper refilled. <b>What corrective action will be accomplished for resident found to be affected by deficient practice?</b> All resident rooms have the potential to be affected. Environmental Service Director or designee shall perform audits of resident floors and corners, closet doors, door frames, sink drains, and resident room walls for North and South nursing rooms. Any discrepancy shall result in immediate correction by housekeeping staff of sanitary conditions or work</p>	03/25/2015

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	<p>10:18 a.m., Room #4 was observed to have a hole in the outside of the closet door and gouges in the drywall. The same was observed on 2/18/15 at 8:40 a.m.</p> <p>3. During an observation on 2/12/15 at 9:58 a.m., Room #7 was observed to have paint chipped off the wall, the bathroom door frame was marred, dirt and debris was built up around the edges of the cove base of the room and bathroom, and a brownish-yellow stain was observed around the drain in the bathroom sink. The same was observed on 2/18/15 at 9:20 a.m.</p> <p>4. During an observation on 2/12/15 at 9:52 a.m., Room #10 was observed to have holes outside of the bathroom door and 2 holes in the bathroom wall, a brownish-yellow stain around the drain in the bathroom sink, and a brownish stain around the base of the commode. The same was observed on 2/18/15 at 8:45 a.m.</p> <p>5. During an observation on 2/12/15 at 9:52 a.m., Room #26 was observed to have used gloves lying on the floor next to the waste basket in the room, a brownish-yellow stain was around the drain in the bathroom sink, and the</p>		<p>order completion for any additional needed repairs. <b>What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b> To enhance currently complaint operations, under the direction of the Director of Nursing or designee, environmental services staff(maintenance, housekeeping laundry) and team leaders shall receive in-servicing regarding area cleaning duty worksheet and resident room deep clean guidelines. In-service will also include work order expectations and preventive maintenance painting schedule. Housekeeping staff shall complete return demonstration of routine area cleaning duties, resident room deep clean and completion of work orders for needed repairs. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> Environmental services director or designee shall monitor daily cleaning worksheet and deep clean schedule daily 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for four weeks, and then monthly for 3 months to ensure resident rooms are maintained in a safe and sanitary environment. Random audits shall continue thereafter and be reported to Quality Assurance Committee. Variation in protocol or processing will result in immediate correction.</p>		

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	<p>bathroom had screw holes next to the call light.</p> <p>6. During an observation on 2/18/15 at 9:11 a.m., Room #26 was observed to have a used Kleenex under the bed and pieces of paper on the floor at the head of the bed. There was no toilet paper in the bathroom and the bathroom waste basket was overflowing.</p> <p>The "Area Cleaning Duties" obtained from the Adm (Administrator) on 2/23/15 at 2:55 p.m., indicated all residents were to have the sinks cleaned and the baseboards washed, all floors were to be dusted, mopped, or vacuumed, and trash was to be removed from all cans on the units daily.</p> <p>A form titled, "Environmental Services, Resident Room, Deep Clean Form" obtained from the Adm on 2/23/15 at 2:55 p.m., indicated the cove base under the sink was to be cleaned and sanitized, toilet paper dispenser filled and walls and doors were to be cleaned and sanitized.</p> <p>During an interview on 2/23/15 at 2:55 p.m., the Adm indicated the rooms are deep cleaned whenever a resident is discharged unless the resident is a long term resident and then the facility deep cleaned the room on a rotation.</p>		<p>Audits shall be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless QA committee deems 100% compliance was achieved. Completion Date 3-25-15</p>				

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R000000	3.1-19(f)  These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R000000	Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of regulatory required response and is not to be construed as agreement with the deficiencies cited.		
R000356	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, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.  Based on interview and record review, the facility failed to ensure that 1 of 5 current residents in a total sample of 7	R000356	<b><u>R356 Clinical Records Emergency File What corrective action will be accomplished for resident</u></b>	03/25/2015	

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	<p>(seven) residents reviewed had a immediately accessible emergency information file available, in case of emergency. (Resident #118)</p> <p>Findings include:</p> <p>The Emergency Information File for Assisted Living (residential) residents was requested from LPN #3 on 2/23/15 at 9:40 a.m. LPN #3 indicated Resident #118 did not have the emergency information in the Emergency Information File book. LPN #3 indicated the MR (Medical Records) person is responsible for the upkeep of the Emergency Information File.</p> <p>During an interview on 2/23/15 at 9:45 a.m., the MR (Medical Records) person indicated she had copied the papers relating to the emergency information file and had given them to the nurse to place in the book. The MR person indicated she did not check if the information was placed into the file book. The MR person indicated she did a quarterly audit of the Emergency Information File in October, 2014, and the audit was not due to be done again. The MR person indicated she would copy the necessary papers and place them in the Emergency Information File immediately.</p>		<p><b>found to be affected by deficient practice?</b> Resident #118 continues to reside at the facility and has suffered no, ill effects from the alleged deficiency. Resident #118 emergency information file was updated and placed in the emergency information file book on 2-23-15. <b>What corrective action will be accomplished for resident found to be affected by deficient practice?</b> All residents have the potential to be affected by the cited deficiency. Medical records or designee shall audit the emergency file book in residential care for completion. Residents identified to need an updated emergency information file shall be implemented immediately. <b>What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b> To enhance currently complaint operations, under the direction of Medical Records or designee, licensed nurse staff and QMA's shall receive in-servicing regarding Emergency Information File for Assisted Living. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> All new admissions to assisted living shall be audited by Medical records or designee for emergency information file completion and placement in the book. Any discrepancy shall be corrected</p>				

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R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.		immediately. Medical records or designee shall audit emergency information file on a quarterly basis to ensure compliance with Assisted Living regulation and present to Quality Assurance Committee for review and recommendation.	

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	<p>(f) For residents 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 be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin 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>Based on interview and record review, the facility failed to provide 1 of 7 residents reviewed for tuberculin skin testing, were not provided with the second step of the skin test on admission. (Resident #118)</p> <p>Findings include:</p> <p>The clinical record of Resident #118 was reviewed on 2/19/15 at 2:20 p.m. Resident #118 had a diagnoses including, but not limited to, chronic obstructive airway disorder and hypertension. The clinical record indicated Resident #118 had been admitted to the facility on 12/1/14. Resident #118 had a physician's order, dated 12/2/14, for the initial and annual PPD(Purified Protein Derivative)/Mantoux screening.</p>	R000410	<p><b><u>R410 Infection Control Tuberculin Test</u> What corrective action will be accomplished for resident found to be affected by deficient practice?</b> Resident #118 continues to reside at the facility and has suffered no, ill effects from the alleged deficiency. Resident #118 has received TB skin testing and shows no signs of tuberculosis. <b>What corrective action will be accomplished for resident found to be affected by deficient practice?</b> All residents have the potential to be affected by the cited deficiency. Medical Records or designee shall audit all residents for tuberculin skin testing first and second steps. Residents identified with orders for tuberculin testing which have not been completed shall be implemented immediately. <b>What measures will be put in place or systemic changes</b></p>	03/25/2015

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	<p>The Immunization Record indicated Resident #118 had received the first step of the tuberculin skin test on 12/2/14 but had not received the second step.</p> <p>During an interview on 2/19/15 at 2:35 p.m., LPN #3 indicated Resident #118 had not received the second step.</p> <p>During an interview on 2/23/15 at 10:38 a.m., the MDS (Minimum Data Set) coordinator indicated Resident #118 was administered the second step of the tuberculin test on 12/26/14, but the test had never been read.</p> <p>A policy titled, "Content of the Clinical Record" and obtained from the Adm (Administrator) on 2/23/15 at 3:05 p.m., indicated the Mantoux test shall be "administered upon admission and read at forty-eight (48) to seventy-two (72)hours. For admissions who have not had a documented negative Mantoux in the past twelve (12) months, if the first step is negative a second Mantoux test shall be administered at least one (1) week and no more than three(3) weeks after the first test."</p>		<p><b>made to ensure the deficient practice does not recur?</b> To enhance currently complaint operations, under the direction of Medical Records or designee, licensed nurse staff shall receive in-servicing regarding Tuberculin Skin Test requirements for Assisted Living. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> All new admissions to assisted living shall be audited by Medical records or designee for tuberculin test administration and documentation per Assisted Living guidelines. Any discrepancy shall be corrected immediately. Medical records or designee shall audit tuberculin test administration and completion on a quarterly basis to ensure compliance with assisted living regulation and present to Quality Assurance Committee for review and recommendation.</p>		