

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/02/2015
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NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: August 24, 25, 26, 27, 28, 31 and September 1 and 2, 2015</p> <p>Facility number: 000557 Provider number: 155455 AIM number: 100291240</p> <p>Census bed type: SNF: 13 SNF/NF:114 Residential:4 Total: 131</p> <p>Census payor type: Medicare: 13 Medicaid: 91 Other: 27 Total: 131</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on September 8, 2015.</p>	F 0000		

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

TITLE

(X6) DATE

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

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F 0164 SS=D Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident privacy was maintained while receiving medical treatment for 1 of 33</p>	F 0164	The facility is unable to correct the alleged deficient practice for resident #187. All residents have the potential to be affected by the alleged deficient practice. All nursing staff to be in-serviced	10/02/2015

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F 0241 SS=D Bldg. 00	<p>residents residing on the Fireside Unit. (Resident # 187) Findings include: On 8/31/15 at 12:05 p.m., Resident #187 was observed seated in his wheelchair outside of the Fireside Hall nurse's station, near the entrance to the Dining Room. QMA #1 approached the resident and performed a glucometer test (blood sugar test) while he remained in the area outside of the nurse's station. The immediate area had multiple residents and staff present, as they were preparing for lunch service in the Dining Room. During an interview, on 9/1/15 at 3:10 p.m., the D.O.N. indicated blood glucose was not to be checked in public areas of the facility.</p> <p>3.1-3(p)(2)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to</p>	F 0241	<p>regarding dignity issues and the appropriate setting for performing a glucometer test. Unit Manager/designee to perform glucometer check observations 2 times a week for 4 weeks, 1 time weekly for 4 weeks, monthly for 2 months, then quarterly ongoing. DON/designee to review results of all observations. Observation results will be reviewed during QA meeting monthly times 2 months, then quarterly ongoing.</p> <p>The facility is unable to correct the alleged deficient practice for residents #108, 110 and 136.All residents have the</p>	10/02/2015			

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	<p>protect resident dignity at meals during 2 of 2 dining observations on the Memory Lane unit. (CNA #9 & 10, CNA #15; Resident # 108, 110, & 136)</p> <p>Findings include:</p> <p>1. During a dining observation on the Memory Lane Unit, on 8/24/15 beginning at 12:22 p.m., the following was observed:</p> <p>a. CNA #9 began assisting Resident #108 while standing over her.</p> <p>b. CNA #10 reached over Resident #108 and placed a tray in the middle of the table between Resident #108 and Resident #136.</p> <p>c. CNA #10 assisted Resident #136 from across the table.</p> <p>d. CNA #10 spoke to LPN #1 across the dining room to call and get a tray for "that new lady" because the kitchen hadn't sent one.</p> <p>2. During a dining observation on the Memory Lane Unit, on 8/31/15 beginning at 12:27 p.m., the following was observed:</p> <p>Resident #136 was seated at a table with 2 other residents. Resident #108 was seated, with her head down and eyes closed, at a table to the left of Resident</p>		<p>potential to be affected by the alleged deficient practice. All nursing staff to be in-serviced regarding dignity and how to appropriately assist residents with their dining experience. Nurse Managers/designee to perform dining room observation check off's 2 times weekly for 4 weeks, then weekly ongoing. DON/designee to review results of all observations after completion. Observation results will be reviewed during QA meeting monthly ongoing.</p>				

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F 0242 SS=D Bldg. 00	<p>#136's table. Both tables were touching at the corner, near Resident #136's seat. CNA #15 moved Resident #136 in her chair, causing the resident to sit parallel with the table, facing Resident #108. CNA #15 then placed a chair at the point where the 2 tables met. CNA #15 began assisting Resident #136, who was seated to her right, to eat. CNA #15 would then stretch over the table on the left and assist Resident #108 without verbal warning. CNA #15's back side of her body would be facing Resident #136. This continued for the duration of the meal.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to follow a resident's personal choices related to wake time in the mornings for 1 of 3 residents reviewed for choices. (Resident #48)</p>	F 0242	The facility is unable to correct the alleged deficient practice for resident #48. All residents with the diagnosis of Congestive Heart Failure whom require weight monitoring have the potential to be affected by the alleged	10/02/2015			

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	<p>Findings include:</p> <p>The clinical record for Resident #48 was reviewed on 8/28/15 at 1:21 p.m. Current diagnoses included, but were not limited to, heart failure, chronic obstructive pulmonary disease, acute ischemic heart disease, generalized edema, essential (primary) hypertension and chronic kidney disease.</p> <p>A review of Resident #48's current physician orders indicated: "Obtain weight twice weekly due to CHF [Congestive Heart Failure] - Notify physician of weight increase of 2 pounds or more in 1 week. One time a day every Tue, [Tuesday] Fri [Friday]" with a start date of 11/21/14.</p> <p>A review of Resident #48's weights and progress notes indicated:</p> <p>7/14/15 - no weight - "...7/14/2015 05:22 [5:22 a.m.] Type: eMAR Medication Administration Note...Resident refused, stating she is not getting up this early. This nurse approached resident later with resident stating 'Get out I'm sleeping'...."</p> <p>7/17/15 - no weight or progress note related to no weight.</p>		deficient practice. Social Services to complete new choice forms for CHF residents to determine those that choose to refuse early morning weights. Results of reviews will be given to DON/designee. DON/designee will audit the choice forms when entering weight times for CHF residents to ensure resident choices are being honored. CHF resident choices will be reviewed during the monthly QA committee meetings ongoing.				

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	7/21/15 - no weight. "...7/21/2015 05:37 [5:37 a.m.] Type: eMAR Medication Administration Note...Resident refused care this AM, as well as refusal to allow staff to get her weight this AM...." No additional attempts to weigh resident were noted.						
	7/24/15 - no weight. "...7/24/2015 05:59 [5:59 a.m.] Type: eMAR Medication Administration Note...resident refused [weight]...." No additional attempts to weigh resident were noted.						
	7/28/15 - no weight. "...7/28/2015 05:35 [5:35 a.m.] Type: eMAR Medication Administration Note...Resident refused [to be weighed] this AM. Resident stated she is not getting up this AM...." No additional attempts to weigh resident were noted.						
	7/31/15 - no weight. "...7/31/2015 06:12 [6:12 a.m.] Type: eMAR Medication Administration Note...Resident refused weight this morning...." No additional attempts to weigh resident were noted.						
	8/4/15 - no weight. "...8/4/2015 05:19 [5:19 a.m.] Type: eMAR Medication Administration Note...Resident refused to be weighed this a.m...." No additional attempts to weigh resident were noted.						

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	<p>8/11/15 - no weight. "...8/11/2015 06:16 [6:16 a.m.] Type: eMAR Medication Administration Note...Resident refused [to be weighed]..." No additional attempts to weigh resident were noted.</p> <p>8/14/15 - no weight. "...8/14/2015 06:05 [6:05 a.m.] Type: eMAR Medication Administration Note...resident refused weight..." No additional attempts to weigh resident were noted.</p> <p>8/18/15 - no weight. "...8/18/2015 06:28 [6:28 a.m.] Type: eMAR Medication Administration Note...Resident refused to be weighed this shift..." No additional attempts to weigh resident were noted.</p> <p>8/21/15 - no weight or progress note related to no weight.</p> <p>The progress notes indicated Resident #48 was awakened anywhere from 5:19 a.m. until 6:28 a.m. to obtain a dry weight.</p> <p>A review of Resident #48's current Health Care Plan indicated the following: "...I have specific choices..." Date initiated: 08/03/2015. Interventions included but were not limited to "...I choose to get up in the morning around 8-9 a.m." Date initiated: 08/05/2015.</p>			

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	<p>A review of "CHOICES FOR RESIDENT CARE", dated 5/8/2015, for Resident #48 provided by the Social Service Director on 8/31/15 at 10:55 a.m. indicated the following:</p> <p>"...1. Around what time would you like to get up in the morning?" A check mark was on the 8-9 a.m. line.</p> <p>During an interview with the Social Service Director, on 8/31/15 at 10:53 a.m., she indicated the resident choices are communicated to staff through books on the units for staff to review.</p> <p>During a review of "RESIDENT CHOICE FORMS" book, provided by RN #3 on 8/31/15 at 11:04 a.m., it indicated no resident choice form for Resident #48. The RN indicated the staff would refer to the resident choice book for the time a resident would want to get up in the mornings.</p> <p>During an interview with RN #4 on 8/31/15 at 11:11 a.m., she indicated there was a resident's choice binder at the nurse's station that had all the residents' preferences in it. RN #4 indicated Resident #48 preferred to eat in her room and hall trays were delivered usually around 8 a.m. She indicated residents who have congestive heart failure were</p>			

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F 0282 SS=D Bldg. 00	<p>weighed by the third shift. RN #4 further indicated she was not sure what they would do for a resident that did not prefer to get up until 8-9 a.m. but would ask.</p> <p>During an interview with RN #4 on 8/31/15 at 11:18 a.m., she indicated no resident choice form for Resident #48 was in the Resident Choice Binder.</p> <p>During an interview with the Nurse Consultant and the DON (Director of Nursing) on 8/31/15 at 12:10 p.m., the DON indicated staff would waken Resident #48 to get her weight and then the resident could go back to bed.</p> <p>No further information was provided by exit on 9/2/15 at 4:10 p.m.</p> <p>3.1-3(u)(3)</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. Based on record review and interview, the facility failed to follow the care plan related to resident specific choices, behavioral symptoms of resisting care,</p>	F 0282	The facility is unable to correct the alleged deficient practice for resident #48. All CHF residents requiring weight monitoring have the potential to be affected by the	10/02/2015

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	<p>and congestive heart failure 1 of 5 residents reviewed for unnecessary medications. (Resident #48)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #48 was reviewed on 8/28/15 at 1:21 p.m. Current diagnoses included, but were not limited to, heart failure, chronic obstructive pulmonary disease, unspecified Alzheimer's disease, unspecified dementia without behavioral disturbance, acute ischemic heart disease, generalized edema, vascular dementia with behavioral disturbance, essential (primary) hypertension and chronic kidney disease.</p> <p>A review of a quarterly Minimum Data Set (MDS), dated 8/9/15, indicated Resident #48 had moderate cognitive impairment.</p> <p>A review of Resident #48's current physician orders indicated the following: "Obtain weight twice weekly due to CHF [Congestive Heart Failure] - Notify physician of weight increase of 2 pounds or more in 1 week. One time a day every Tue, [Tuesday] Fri [Friday]" with a start date of 11/21/14.</p> <p>A review of Resident #48's weights and</p>		<p>alleged deficient practice. Nursing staff will be in-serviced regarding 2 additional attempts to reweigh a CHF resident upon the first refusal. MD is to be notified upon the 3rd refusal. All careplans for CHF residents requiring weight monitoring will be reviewed and updated to include nursing to complete assessment if resident is symptomatic for signs/symptoms of CHF, ie; shortness of breath, audible wheezes, edema, etc. DON/designee to review CHF weights weekly to ensure weights have been obtained and/or MD notified of refusals. Results of reviews will be discussed during monthly QA meetings ongoing.</p>	

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	<p>progress notes indicated the following:</p> <p>7/14/15 - no weight - "...7/14/2015 05:22 [5:22 a.m.] Type: eMAR Medication Administration Note...Resident refused, stating she is not getting up this early. This nurse approached resident later with resident stating get out I'm sleeping...."</p> <p>7/17/15 - no weight or progress note related to missing weight.</p> <p>7/21/15 - no weight. "...7/21/2015 05:37 [5:37 a.m.] Type: eMAR Medication Administration Note...Resident refused care this AM, as well as refusal to allow staff to get her weight this AM...." No additional attempts to weigh resident were noted.</p> <p>7/24/15 - no weight. "...7/24/2015 05:59 [5:59 a.m.] Type: eMAR Medication Administration Note...resident refused [weight]...." No additional attempts to weigh resident were noted.</p> <p>7/28/15 - no weight. "...7/28/2015 05:35 [5:35 a.m.] Type: eMAR Medication Administration Note...Resident refused [to be weighed] this AM. Resident stated she is not getting up this AM..." No additional attempts to weigh resident were noted.</p>			

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	<p>7/31/15 - no weight - "...7/31/2015 06:12 [6:12 a.m.] Type: eMAR Medication Administration Note...Resident refused weight this morning...." No additional attempts to weigh resident were noted.</p> <p>8/4/15 - no weight. "...8/4/2015 05:19 [5:19 a.m.] Type: eMAR Medication Administration Note...Resident refused to be weighed this a.m...." No additional attempts to weigh resident were noted.</p> <p>8/11/15 - no weight. "...8/11/2015 06:16 [6:16 a.m.] Type: eMAR Medication Administration Note...Resident refused [to be weighed]...." No additional attempts to weigh resident were noted.</p> <p>8/14/15 - no weight. "...8/14/2015 06:05 [6:05 a.m.] Type: eMAR Medication Administration Note...resident refused weight...." No additional attempts to weigh resident were noted.</p> <p>8/18/15 - no weight. "...8/18/2015 06:28 [6:28 a.m.] Type: eMAR Medication Administration Note...Resident refused to be weighed this shift...." No additional attempts to weigh resident were noted.</p> <p>8/21/15 - no weight or progress note related to missing weight.</p> <p>The progress notes indicated Resident</p>			

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	<p>#48 was awakened anywhere from 5:19 a.m. until 6:28 a.m. to obtain a dry weight.</p> <p>A review of Resident #48's progress notes indicated no assessments for lung sounds, edema, or for excess fluid, skin turgor for the days Resident #48 refused to be weighed. No dry weights were documented or progress notes as to why no weight was obtained for 7/17/15 and 8/21/15.</p> <p>A review of Resident #48's current Health Care Plan indicated the following: "...I have specific choices" Date initiated: 08/03/2015. Interventions included but were not limited to "I choose to get up in the morning around 8-9 a.m." Date initiated: 08/05/2015.</p> <p>"...I have behavioral symptoms...diagnosis of Delusional disorder...resisting care." Date initiated: 08/03/2015. Interventions included, but were not limited to "...If I am choosing not to have care, come back at a later time and re-approach me...Date initiated: 08/03/2015."</p> <p>"...I have secondary hypertension related to...congestive heart failure, coronary artery disease." Date initiated: 11/28/2014. Interventions included, but</p>			

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	<p>were not limited to "...I will be observed for edema and unexplained weight gain... Date initiated: 11/28/2014."</p> <p>During an interview with the Nurse Consultant and the DON (Director of Nursing) on 8/31/15 at 12:10 p.m., the DON indicated staff would waken Resident #48 to get the dry weight and then the resident could go back to bed. The Nurse Consultant and DON both indicated no policy for congestive heart failure protocol was available.</p> <p>During an interview with RN #3 on 8/31/15 at 1:12 p.m., she indicated if a resident would refuse to be weighed that had congestive heart failure then they would re-attempt to weigh the resident. She further indicated no assessments were completed on a resident with congestive heart failure if that resident had refused to be weighed.</p> <p>She indicated once it was found that a resident had gained weight, based on the physician parameters, then the resident would be on 72 hour assessments, which would include listening to lung sounds, observing for edema, shortness of breath, and cough.</p> <p>During an interview with RN #4 on 8/31/15 at 1:02 p.m., she indicated, if</p>			

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F 0309 SS=D Bldg. 00	<p>there was an increase in weight based on physician parameter, there would be a 72 hour alert charting where every shift monitors for sign and symptoms of heart failure or congestive heart failure. She indicated symptoms might include shortness of breath, edema, increased pulse and included assessment of lung sounds, and the oxygen saturation level.</p> <p>RN #4 further indicated she would not know if the resident has gained or lost weight if the resident has not been weighted due to refusals. She indicated that with an increase in weight the 72 hour alert charting would be done, but was unsure what to do in case of refusals.</p> <p>No further information was provided by exit on 9/2/15 at 4:10 p.m.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>				

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	<p>A. Based on record review and interview, the facility failed to assess a resident for signs and symptoms related to congestive heart failure who refused to have dry weights, failed to re-attempt to obtain weights and failed to obtain a weight for 1 of 5 residents reviewed for unnecessary medications. (Resident #48)</p> <p>B. Based on observation, record review, and interview, the facility failed to ensure psychotropic medications were not used without indication for 1 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure a behavior management program was implemented and updated for 1 of 1 residents reviewed for behavior management. (Resident # 64 & 152)</p> <p>Findings include:</p> <p>A. The clinical record for Resident #48 was reviewed on 8/28/15 at 1:21 p.m. Current diagnoses included, but were not limited to, heart failure, chronic obstructive pulmonary disease, unspecified Alzheimer's disease, unspecified dementia without behavioral disturbance, acute ischemic heart disease, generalized edema, vascular dementia with behavioral disturbance, essential (primary) hypertension and chronic kidney disease.</p>	F 0309	<p>A - The facility is unable to correct the alleged deficient practice for resident #48. All CHF residents requiring weight monitoring have the potential to be affected by the alleged deficient practice. Nursing Staff will be inserviced regarding 2 additional attempts to reweigh a CHF resident upon the first refusal. MD to be notified upon the 3rd refusal. All careplans for CHF residents requiring weight monitoring will be reviewed and updated to include nursing to complete assessments if the resident is symptomatic for signs/symptoms of CHF, ie, shortness of breath, audible wheezes, edema, etc. Social Services to audit all choice forms for CHF residents to determine those that choose to refuse early morning weights. Results of reviews will be given to the DON/designee. DON/designee to review CHF weights weekly to ensure weights have been obtained and/or MD notified of refusals. DON/designee when entering weight times for CHF residents, will audit the choice forms ensuring resident are being honored. Results of reviews will be discussed during monthly QA meetings ongoing. B - Resident #64's psychoactive medications were reviewed by Psych NP and Seroquel was reduced to 12.5mg daily. Resident #64's behavior careplan was reviewed and updated as indicated. Resident #152's behavior plan was</p>	10/02/2015			

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	<p>A review of a quarterly Minimum Data Set (MDS), dated 8/9/15, indicated Resident #48 had moderate cognitive impairment.</p> <p>A review of Resident #48's current physician orders indicated the following: "Obtain weight twice weekly due to CHF [Congestive Heart Failure] - Notify physician of weight increase of 2 pounds or more in 1 week. One time a day every Tue, [Tuesday] Fri [Friday]" with a start date of 11/21/14.</p> <p>A review of Resident #48's weights and progress notes indicated the following:</p> <p>7/14/15 - no weight - "...7/14/2015 05:22 [5:22 a.m.] Type: eMAR Medication Administration Note...Resident refused, stating she is not getting up this early. This nurse approached resident later with resident stating get out I'm sleeping...."</p> <p>7/17/15 - no weight or progress note related to missing weight.</p> <p>7/21/15 - no weight. "...7/21/2015 05:37 [5:37 a.m.] Type: eMAR Medication Administration Note...Resident refused care this AM, as well as refusal to allow staff to get her weight this AM..." No additional attempts to weigh resident</p>		<p>reviewed and updated as necessary. All resident's receiving an antipsychotic medication have the potential to be affected. All residents receiving an antipsychotic will be reviewed by the IDT. All residents on behavior management program will have their behavior care plan reviewed and updated as necessary. All staff will be in-serviced over behavior management program, documentation of behaviors, and care plan interventions. Behaviors will be reviewed during the clinical meeting with social service follow up as necessary. Behavior care plans will be reviewed and updated as necessary. IDT will review any changes in antipsychotic medications during the clinical meeting to ensure medications used with appropriate indication. Social Service Director or Designee will interview three staff members weekly for 12 weeks, then monthly for 3 months regarding behavior management program and interventions implemented. All findings will be reviewed in QA meeting quarterly ongoing.</p>	

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	<p>were noted.</p> <p>7/24/15 - no weight. "...7/24/2015 05:59 [5:59 a.m.] Type: eMAR Medication Administration Note...resident refused [weight]...." No additional attempts to weigh resident were noted.</p> <p>7/28/15 - no weight. "...7/28/2015 05:35 [5:35 a.m.] Type: eMAR Medication Administration Note...Resident refused [to be weighed] this AM. Resident stated she is not getting up this AM..." No additional attempts to weigh resident were noted.</p> <p>7/31/15 - no weight - "...7/31/2015 06:12 [6:12 a.m.] Type: eMAR Medication Administration Note...Resident refused weight this morning...." No additional attempts to weigh resident were noted.</p> <p>8/4/15 - no weight. "...8/4/2015 05:19 [5:19 a.m.] Type: eMAR Medication Administration Note...Resident refused to be weighed this a.m...." No additional attempts to weigh resident were noted.</p> <p>8/11/15 - no weight. "...8/11/2015 06:16 [6:16 a.m.] Type: eMAR Medication Administration Note...Resident refused [to be weighed]...." No additional attempts to weigh resident were noted.</p>				

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	<p>8/14/15 - no weight. "...8/14/2015 06:05 [6:05 a.m.] Type: eMAR Medication Administration Note...resident refused weight..." No additional attempts to weigh resident were noted.</p> <p>8/18/15 - no weight. "...8/18/2015 06:28 [6:28 a.m.] Type: eMAR Medication Administration Note...Resident refused to be weighed this shift..." No additional attempts to weigh resident were noted.</p> <p>8/21/15 - no weight or progress note related to missing weight.</p> <p>The progress notes indicated Resident #48 was awakened anywhere from 5:19 a.m. until 6:28 a.m. to obtain a dry weight.</p> <p>A review of Resident #48's progress notes indicated no assessments for lung sounds, edema, or for excess fluid, skin turgor for the days Resident #48 refused to be weighed. No dry weights were documented or progress notes as to why no weight was obtained for 7/17/15 and 8/21/15.</p> <p>A review of Resident #48's current Health Care Plan indicated the following: "...I have specific choices" Date initiated: 08/03/2015. Interventions included but were not limited to "I</p>			

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	<p>choose to get up in the morning around 8-9 a.m." Date initiated: 08/05/2015.</p> <p>"...I have behavioral symptoms...diagnosis of Delusional disorder...resisting care." Date initiated: 08/03/2015. Interventions included, but were not limited to "...If I am choosing not to have care, come back at a later time and re-approach me...Date initiated: 08/03/2015."</p> <p>"...I have secondary hypertension related to...congestive heart failure, coronary artery disease." Date initiated: 11/28/2014. Interventions included, but were not limited to "...I will be observed for edema and unexplained weight gain... Date initiated: 11/28/2014."</p> <p>A review of "CHOICES FOR RESIDENT CARE" dated 5/8/2015 for Resident #48 provided by the Social Service Director on 8/31/15 at 10:55 a.m. indicated: "...1. Around what time would you like to get up in the morning?" A check mark was on the 8-9 a.m. line.</p> <p>During an interview with RN #4 on 8/31/15 at 11:11 a.m., she indicated there was a resident's choice binder at the nurse's station that had all the residents' preferences in it. RN #4 indicated</p>			

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	<p>Resident #48 preferred to eat in her room and hall trays were delivered usually around 8 a.m. She indicated residents who have congestive heart failure were weighed by the third shift. RN #4 further indicated she was not sure what they would do for a resident that did not prefer to get up until 8-9 a.m. but would ask.</p> <p>During an interview with RN #4 on 8/31/15 at 11:18 a.m., she indicated no resident choice form for Resident #48 in the Resident Choice Binder.</p> <p>During an interview with the Nurse Consultant on 8/31/15 at 11:50 a.m., she indicated assessments such as lung sounds, edema, respiratory, etc...would be documented in the nurse's notes/progress notes.</p> <p>During an interview with the Nurse Consultant and the DON (Director of Nursing) on 8/31/15 at 12:10 p.m., the DON indicated staff would waken Resident #48 to get the dry weight and then the resident could go back to bed. The Nurse Consultant and DON both indicated no policy for congestive heart failure protocol was available.</p> <p>During an interview with RN #3 on 8/31/15 at 1:12 p.m., she indicated if a resident would refuse to be weighed that</p>			

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	<p>had congestive heart failure then they would re-attempt to weigh the resident. She further indicated no assessments were completed on a resident with congestive heart failure if that resident had refused to be weighed.</p> <p>She indicated once it was found that a resident had gained weight, based on the physician parameters, then the resident would be on 72 hour assessments, which would include listening to lung sounds, observing for edema, shortness of breath, and cough.</p> <p>During an interview with RN #4 on 8/31/15 at 1:02 p.m., she indicated, if there was an increase in weight based on physician parameter, there would be a 72 hour alert charting where every shift monitors for sign and symptoms of heart failure or congestive heart failure. She indicated symptoms might include shortness of breath, edema, increased pulse and included assessment of lung sounds, and the oxygen saturation level.</p> <p>RN #4 further indicated she would not know if the resident has gained or lost weight if the resident has not been weighted due to refusals. She indicated that with an increase in weight the 72 hour alert charting would be done, but was unsure what to do in case of refusals.</p>			

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	<p>During an interview with the Nurse Consultant and DON on 8/31/15 at 2:45 p.m., the Nurse Consultant indicated staff would not assess resident lung sounds if the weights had been refused unless the resident was symptomatic. She further indicated you would hear if the resident had crackles by the audible sound the resident would make.</p> <p>No further information was provided by exit on 9/2/15 at 4:10 p.m.</p> <p>B.1. Review of Resident #64's clinical record began on 8/28/15 at 1:55 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, Alzheimer's disease, depression, anxiety, and dementia with delusional features.</p> <p>Resident #64's current physician orders indicated Resident #64 received the following psychotropic medications: Zoloft (an antidepressant) 50 mg once daily and Seroquel (an antipsychotic) 25 mg once daily.</p> <p>Resident #64 had a current, 7/21/15, quarterly MDS (Minimum Data Set) assessment, which indicated the she was cognitively intact. The MDS assessment also indicated Resident #64 had not experienced any hallucinations or delusions during the assessment period.</p>				

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	<p>Resident #64's clinical record indicated the current administration of an antipsychotic medication began on 9/20/14 with Seroquel 12.5 mg once daily.</p> <p>Review of a psychologist "Mental Health Treatment Plan", dated 12/19/14, indicated Resident #64's short term treatment objectives included, but were not limited to, "verbalizing positive comments, rather than ...her usual complaints and negatives...."</p> <p>Psychiatric "Progress Notes", dated 2/16/15, 4/1/15, and 6/2/15, indicated lack of delusional thoughts or hallucinations.</p> <p>Psychiatric "Progress Notes", dated 4/1/15, indicated the resident had been angry, tearful, and had made negative statements to staff and had cursed at them. The notes further indicated the nurse had informed the clinician the resident's statements had a "...sexual connotation [sic]...." to them.</p> <p>There was no documentation of behaviors of a sexual nature found in the resident's clinical record for April, 2015.</p> <p>An "Initial Psychological Evaluation",</p>			

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	<p>dated 4/24/15, indicated Resident #64 denied current or past hallucinations or delusions and was not a candidate for psychotherapy nor behavior management. The notes further indicated the resident had symptoms related to depression and was fixated on moving out of the facility and living independently.</p> <p>Psychiatric "Progress Notes", dated 6/2/15, indicated an acute visit for "...increased behaviors over the last several days..." of yelling in hallways and "...threatening to smear feces on the wall and later doing exactly this...", mumbling under her breath, and cursing at staff. Orders were written to increase Seroquel to 25 mg to help with "...agitated delusions...", but no documentation of any delusions was present.</p> <p>Review of a "Behavior Sheet", dated 5/31/15, indicated the resident was yelling repeatedly for more toilet paper, "...wanted 3 more rolls brought in to her..." but had a full roll on the wall. The document further indicated the resident later smeared feces on the wall and had cursed at the nurse.</p> <p>Review of a "Behavior Sheet", dated 6/2/15, indicated Resident #64 had been seen pouring water from a pitcher into a wastebasket and then "...mumbled</p>						

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	<p>something under her breath...." when reminded not to pour water into the wastebasket.</p> <p>There was no other documentation of behaviors for the month of May 2015.</p> <p>A "Social Service Behavior Assessment (for New or Worsening Behaviors)", dated 6/23/15, indicated "...she has been yelling, threatening, pouring water in trash cans, crying excessively. She does not like change. She has a tendency to be negative...."</p> <p>Review of "Behavior Management Team" documents, dated 7/8/15 and 8/13/15 indicated Resident #64 was placed on behavior management for negative statements, delusional thoughts, and resisting care. The precipitating factor causing the resident behaviors was identified as the resident not wanting to be in a nursing home.</p> <p>During an interview on 9/01/2015 at 2:29 p.m., RN #1 indicated the care plan interventions didn't usually work and the resident was known by her family to be "cantankerous".</p> <p>During an interview, on 9/2/15 at 1:11 p.m., the SSD (Social Service Director) indicated Resident #64's delusions were</p>			

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	<p>that she wanted to go home and her family was looking for a house for her, but none had been documented.</p> <p>B.2. On 08/25/2015 at 10:18 a.m., Resident #152 was observed to take her shirt off in the dining room during activity time. Resident #152 was observed sitting in the dining room in a sports bra and pants in her chair. Resident #152 was observed to have nothing on her table or in her hands. Resident #152 was observed wearing no shirt for two minutes.</p> <p>On 08/25/2015 at 1:26 p.m., upon entrance to the Memory Lane Unit, Resident #152 was observed to be sitting in the dining area wearing a sports bra and pants but no shirt. Resident #152 was observed sitting in the dining room with ten residents, one visitor, and 1 LCSW present. Nothing was observed to be in Resident #152's hands or on the table in front of her.</p> <p>On 08/25/2015 at 1:50 p.m., Resident #152 was observed to be taking her shirt off in the dining room. Nothing was observed in Resident #152's hands or on the table in front of her.</p> <p>On 08/31/2015 at 3:23 p.m., upon entrance to the the Memory Lane Unit,</p>			

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	<p>Resident #152 was observed sitting in wheelchair in the dining room in a sports bra and pants. No shirt was observed on Resident #152. There were six residents observed to be in the dining room with Resident #152. Resident #152 was observed to have nothing on her table or in her hands. Resident #152 was observed without a shirt on for one minute.</p> <p>On 08/31/2015 at 3:24 p.m., Certified Nurses Aide (CNA) #1 placed a shirt on Resident #152. Resident #152 was then observed to be bunching up the shirt in front, exposing her abdomen and sides. Resident #152 was observed to have nothing on her table.</p> <p>On 09/01/2015 at 8:53 a.m., upon entrance to the Memory Lane Unit, Resident #152 was observed to be sitting in the dining room wearing a sports bra and pants. No shirt was observed on the resident.</p> <p>On 09/01/2015 at 8:55 a.m., CNA #1 and Nursing Consultant #1 were observed to approach Resident #152. CNA #1 picked the shirt up off the floor and took the shirt to the soiled utility room while Nursing Consultant #1 stood in front of Resident #152. Resident #152 did not wear a shirt for 2 minutes. Seventeen</p>			

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	<p>residents, three CNA's, and one Nursing Consultant were in the dining room at this time.</p> <p>During a dining observation on 8/31/15 at 12:31 p.m., Resident #152 attempted to take her white t-shirt off. LPN #1 intervened and gave the resident puzzle pieces. Resident #152 put a few of the puzzle pieces down her teal colored pants after LPN #1 walked away.</p> <p>During an interview with LPN #1 on 8/31/15 at 12:54 p.m., LPN #1 indicated she had wondered where the puzzle pieces had gone.</p> <p>During an interview with CNA #2 on 9/1/15 at 1:52 p.m., she indicated Resident #152 would be given a puzzle to do as an intervention and the resident would get bored with it. CNA#2 indicated she was unsure what would trigger Resident #152 to disrobe. She indicated it could be that she was bored.</p> <p>During an interview with CNA #1 on 9/1/15 at 2:09 p.m., she indicated Resident #152 seemed to get tired of messing with the puzzles and stuffed animals. She indicated she felt there needed to be other interventions added.</p> <p>During an interview with LPN #1 on</p>				

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	<p>9/1/15 at 2:25 p.m., she indicated it seemed to be a tactile thing with Resident #152, she had to have something in her hands.</p> <p>Review of Resident # 152's clinical record began on 9/2/15 at 7:50 a.m. Diagnoses included, but were not limited to, frontal lobe dementia, depression, anxiety, and dementia with behavioral disturbances.</p> <p>Resident #152 had a current, 7/1/15 quarterly MDS, which indicated the resident's cognitive function could not be assessed.</p> <p>A "Social Service Behavior Assessment (for New or Worsening Behaviors), dated 12/9/14, indicated Resident #152's behaviors were as follows: "refusing to dress, disrobing, rummaging, and stripping linens." It further indicated the resident would be placed on a behavior management program.</p> <p>Progress notes titled, "Social Service Behavior", dated 8/3/15 through 9/1/15, indicated multiple interventions were tried to alleviate the resident's disrobing. A note, on 8/20/15 indicated interventions were attempted 22 times and as many as 25 times on 8/24/15. Outcome for both dates was documented</p>			

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	<p>as the behavior being "unchanged."</p> <p>There was no documentation of the resident disrobing from 8/3/15 through 8/17/15. There was no documentation regarding assessment of the lack of behavior for this time period in the clinical record.</p> <p>Monthly "Behavior Management Team" documents, dated from 12/9/14 through 6/9/15, indicated the precipitating factor for Resident #152's behaviors was identified as dementia. The Resident's diagnosis of hypothyroidism was added as of 7/5/15.</p> <p>Resident #152 had a current care plan problem of behavioral symptoms such as disrobing in public areas. Interventions included, but were not limited to, the following: "...Allow me to express my feelings, ...Diversional activity such as puzzles, decorating and reading. I will fold clothes also. I enjoy doing the sort box as well, "...task such as eating...."</p> <p>Review of a policy, titled "Behavior Management", dated 6/2012, provided by the DON on 9/2/15 at 8:47 a.m., indicated the following:</p> <p>"...16. Social Services will review behaviors daily Monday through Friday</p>			

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F 0371 SS=F Bldg. 00	<p>in the clinical meeting...."</p> <p>During an interview with the Social Service Director, on 9/2/15 at 1:11 p.m., she indicated she was not aware Resident #152 did not have behaviors occur from 8/3/15 through 8/17/15. She indicated she would check with staff to inquire about what interventions were helpful during this time period, so they could be evaluated for inclusion in the resident's behavior management program.</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions. Of the facility's 128 residents, this deficient practice had the potential to impact 128 who were served food from the facility's kitchen.</p> <p>Findings include:</p>	F 0371	All unlabeled and updated portioned out items for that day were immediately labeled/dated for 8-24-15. The large stainless steel mixer/bowl and meat slicer were re-cleaned, checked by the Dietary Manager and recovered. Maintenance immediately cleaned the range hood and sprinkler system. The griddle was cleaned by Dietary upon noticing the substance. The three sink compartment rinse water	10/02/2015			

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	<p>1. During a dining observation, beginning on 8/24/15 at 12:09 p.m., QMA #1 served Resident #11's tray following a 7 second hand wash at the dining room sink. QMA #1 then placed a piece of bread in her left open palm and spread peanut butter on the bread. QMA#1 then placed a second piece of bread on top with her bare right hand and placed the sandwich on the plate. While holding the sandwich on the plate with her bare left hand, QMA #1 cut the sandwich in half. She then separated the 2 halves of the sandwich with her bare hands.</p> <p>2. Kitchen sanitation tour accompanied by the Dietary Manager on 8/24/15 at 9:33 a.m. indicated the following:</p> <p>a. Eleven unlabeled and undated, single serving plastic bowls of chicken salad were located in the walk-in refrigerator ready to serve.</p> <p>b. An uncovered, large, stainless steel mixer and bowl, located in the food prep area, had a dried white substance on the bottom of the mixer adaptor. Dietary aide #6 indicated the mixer was ready to use and had not been used that morning. The Dietary Manager indicated the bottom of the mixer adaptor needed to be</p>		<p>was disposed of, sink refilled and checked for sanitizer level of 150-400ppm. All wares were sanitized to ensure appropriate sanitization. All residents have the potential to be affected by the alleged deficient practice. Dietary staff will be inserviced regarding appropriate labeling/dating and following cleaning schedules. Nursing staff will be in-serviced regarding appropriate handling of food items and infection control procedures. Dietary Manager to review sanitizer logs, cleaning schedules and will randomly check the cleanliness of kitchen items, the labeling/dating of food items each business day. Dietary Manager will review audits of the dietary department at the monthly QA Committee meetings ongoing.</p>				

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	<p>cleaned and the mixer and bowl needed to be covered when not in use.</p> <p>c. A ready to use and covered, meat slicer had dried brown food particles on the slicer, the electrical cord, and the knobs which were laid on the meat slicer. The Dietary Manager indicated the meat slicer needed to be cleaned and re-covered.</p> <p>d. The sprinkler system attached to the hood located over the stove and griddle, had a thick, heavy accumulation of a sticky, dark brown substance, which formed sticky drips that hung from the pipe. The three orange caps on the sprinkler system had an accumulation of the brown sticky substance.</p> <p>e. On 8/24/15 at 9:55 a.m., the three compartment sink rinse water was tested with a chemical test strip by the Dietary Manager. It indicated the color orange, which indicated zero ppm (parts per million) on the chemical test range. The Dietary cook and dietary aide #6 indicated the test strip was orange, which indicated zero on the chemical test range. The Dietary Manager Assistant came into the kitchen at 10:00 a.m. after the Dietary Manager had stepped out and indicated to the dietary cook #7 and the dietary aide #6 that there had been a problem with the</p>			

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	<p>sanitizer machine for awhile now and the chemical test strips should read between 150-400.</p> <p>f. An observation of the two-door stainless refrigerator indicated the following:</p> <p>f1. 16 unlabeled and undated, single serving, plastic bowls of cottage cheese. The Dietary Manager inquired if they needed to be dated if the food items were to be used for the next meal service?</p> <p>f2. Four unlabeled and undated bologna and cheese sandwiches.</p> <p>f3. Five unlabeled and undated plastic cups with liquid. The Dietary Manager indicated they were nectar thick water.</p> <p>f4. Seven unlabeled and undated, plastic cups of lemonade.</p> <p>f5. There was 24 unlabeled and undated plastic cups of tea.</p> <p>f6. The bottom of the two door stainless steel refrigerator had an accumulation of grey dust and debris.</p> <p>During an interview with the Dietary Manager Assistant on 8/24/15 at 10:30 a.m., she indicated the hood over the</p>			

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	<p>stove was not on the cleaning schedule. She further indicated it was last cleaned by an outside contracted service on 3/13/15 and was not due to be cleaned again until 9/13/15 by the outside contracted service.</p> <p>During an interview with Dietary Cook #7 on 8/24/15 at 10:33 a.m., she indicated food should be labeled and dated, otherwise the dietary staff would not know when an item was made, if it was fresh or had been in the refrigerator for a few days or even longer. The cook indicated the dietary staff needed to know when a food item was made or distributed to single servings to tell whether it was fresh or not.</p> <p>During an interview with Dietary Aide #8 on 8/24/15 at 10:35 a.m., he indicated he had forgotten to label and date the items in the two-door stainless steel refrigerator that day.</p> <p>During an interview with the Dietary Manager with the Dietary Consultant present on 8/24/15 at 1:30 p.m., the Dietary Manager indicated the food should be labeled and dated when stored.</p> <p>During an interview with the Dietary Manager on 9/1/15 at 2:45 p.m., she indicated the sanitizer had not been</p>			

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	<p>turned on prior to the rinse water being dispensed into the three compartment sink prior to the observation on 8/24/15.</p> <p>During an interview with the Dietary Manager and the Dietary Consultant on 9/2/15 at 2:05 p.m. the Dietary Consultant indicated the sanitizer chemical test strips the kitchen used to test the 3 compartment sink rinse water with sanitizer added was "Hydrion Papers QT-40. She indicated she preferred the sanitizer chemical test strips read 200 ppm which would be a light green color. She indicated the chemical strip test range for effective amounts of sanitizer was between 150 ppm and 400 ppm though.</p> <p>A review of "Cleaning Schedules" provided by the Dietary Manager on 8/24/15 at 10:40 a.m. indicated the following:</p> <p>"...Date assigned_August 4, 2015 Date to be completed AUGUST 11TH 2015... ...Wash the entire outside of refrigerator (even the sides) ...Remove everything more than 3 days old... ...Clean entire mixer and the stand it is on...."</p> <p>The cleaning schedule listed dietary staff</p>			

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	<p>assigned to areas to be cleaned but no dates listed of when the items were cleaned. The hood of the range was not listed on the cleaning schedule.</p> <p>A review of "Cleaning Schedules" provided by the Dietary Manager on 8/24/15 at 10:45 a.m. indicated the following:</p> <p>"...assigned_August 19, 2015 Date to be completed AUGUST 26, 2015... ...Wash the entire outside of refrigerator (even the sides) ...Remove everything more than 3 days old..."</p> <p>Signed and dated as completed on 8/19/15 by dietary staff assigned to items.</p> <p>"...Clean the entire mixer and the stand it is on..." No date of completion listed.</p> <p>...also Hood of Range!! altered 8-24..."</p> <p>A review of an undated reference for "Ultimate Sanitizer" provided by the Nurse Consultant on 8/24/15 at 2:59 p.m. indicated the following:</p> <p>"...Features ...Concentrated ...Wide range sanitizer..."</p>			

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	<p>...Benefits</p> <p>...Effective at 150-400 ppm</p> <p>...Disinfectant, laundry sanitizer, deodorizer and hard surface sanitizer...</p> <p>...Recommended Uses</p> <p>...For use in...nursing homes...or wherever an effective quaternary sanitizer or disinfectant is needed...</p> <p>...Directions for use:</p> <p>...FOR USE IN THIRD TANK</p> <p>SANITATION: ...thoroughly wash or flush objects with compatible detergent followed by a potable water rinse before applications of sanitizing solutions. Apply a solution of 1 to 2.67 ounces of this product in 4 gallons (150-400 ppm active) to pre-cleaned, hard surfaces thoroughly wetting surfaces with a cloth...or by immersion...."</p> <p>A review of the policy titled "Manual Warewashing" dated 6/15/12 provided by the Nurse Consultant on 8/24/15 at 1:25 p.m. indicated the following:</p> <p>"...Purpose of Policy & Procedure: To explain the process of using the 3-compartment sink for washing and sanitizing...</p> <p>...Policy: ...The Dietary and Nutritional Services Department will have a sink</p>			

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	<p>with three compartments for manually washing, rinsing, and sanitizing equipment and utensils...</p> <p>...Process/Procedure: ...3c. The third compartment is used for sanitization... ...If quaternary ammonia is used the solution shall:have a concentration of at least 200-400 ppm...."</p> <p>A review of a policy titled "Cleaning of Hood Vents " dated 6/15/12 was provided by the Nurse Consultant on 8/24/15 at 2:59 p.m. and indicated the following:</p> <p>"...Purpose of Policy & Procedures: To assure that the exhaust hoods above the cooking line shall be routinely cleaned...</p> <p>...Process/Procedures: ...3) The hood exterior surface, light covers, and interior surfaces along with the filters shall be routinely cleaned by dietary or maintenance personnel per cleaning schedule..."</p> <p>A review of a policy titled "Cleaning Schedules" with a revision date of 6/12 provided by the Nurse Consultant on 8/24/15 at 2:59 p.m. indicated the</p>			

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	<p>following:</p> <p>"...Purpose of Policy & Procedure: To specify what needs to be cleaned, who is to clean it, and who monitors that assignments are completed...</p> <p>...Policy: The Dietary Manager is responsible for the supervision and training of employees in the proper sanitation procedures for cleaning and maintaining of the kitchen and all equipment used there in. The Dietary Manager is responsible for preparing daily, weekly and deep cleaning schedules...</p> <p>...Process/Procedure: 1) The Dietary Manager creates a Cleaning Schedule covering all areas to be cleaned in the kitchen... ...3) The Cleaning Schedule allows for the "cleaner" to initial and date completion... ...5) The Dietary Manager shall routinely check that cleaning is being done to meet the regulation standards...."</p> <p>A review of the policy titled "Cold Food Preparation" dated 7/08 provided by the Nurse Consultant on 8/24/15 at 2:59 p.m. indicated the following: "...4) All cold items ready for serving are covered, labeled, and dated and placed</p>			

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F 0425 SS=D Bldg. 00	<p>back in the cooler until service time...."</p> <p>3.1-21(i)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to assure expired medications were not given to residents regarding for 3 of 4 opened insulin vials observed during medication storage.</p> <p>Findings include:</p> <p>On 08/28/2015 at 8:35 a.m., during an</p>	F 0425	The facility is unable to correct the alleged deficient practice for residents #47 and 118. The expired insulin vials were immediately disposed of and replacement vials obtained. All residents have the potential to be affected by the alleged deficient practice. All insulin vials were audited to ensure that no others were expired and dated appropriately. All nursing staff will	10/02/2015

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	<p>observation of the medication storage carts in the Fireside Hall, a vial of Levemir (insulin) 100 units/ml for Resident #47 was observed in the drawer and labeled as opened 7/15/15 and "discard after 8/26/15."</p> <p>A vial of Lantus 100 units/ml (insulin) for Resident #118 was observed in the drawer labeled as opened 7/28/2015 and a discard date of 8/25/2015.</p> <p>A vial of Novolog 100 units/ml for Resident #118 was observed in the drawer as opened 7/29/15 and a discard date of 8/26/2015. During an interview with RN #3, she indicated that she was just about to draw up and give this insulin to Resident #118.</p> <p>On 08/28/2015 at 10:36 a.m., during an interview, RN #3 indicated the expiration dates for the insulin should be checked every day before it was given.</p> <p>On 08/28/2015 at 9:57 a.m., the Director of Nursing (DON) provided a policy titled "Storage of Medications" dated 6/2005, the policy indicated "....3. All discontinued, outdated, or deteriorated medications will be destroyed or sent back to the pharmacy...."</p> <p>On 8/28/2015 at 11:38 a.m., the DON</p>		<p>be in-serviced regarding a daily check of insulin vials for expiration date. Nurse Managers to perform a weekly audit of insulin vials to ensure compliance 2 times a week for 4 weeks, 1 time weekly for 4 weeks, monthly for 2 months and then quarterly ongoing. DON/designee to review nurse manager audits upon completion of each audit. Results of audits will be reviewed at QA meeting monthly ongoing.</p>				

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F 0431 SS=E Bldg. 00	<p>provided a chart titled "Insulin Storage Recommendations" which indicated Levemir, when opened, could be stored for 42 days at room temperature. It indicated Novolog, when opened should be stored for 28 days at room temperature. It also indicated a Lantus vial when opened could be stored for 28 days at room temperature.</p> <p>3.1-25(o)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the</p>			

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	<p>keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to properly secure medication during medication pass for 2 of 8 days of the survey. The facility failed to ensure medications for 3 residents were stored in properly labeled containers for 2 of 6 medication carts observed during the survey.</p> <p>Findings include:</p> <p>On 8/26/15 at 8:25 a.m., during medication pass with Registered Nurse (RN) #3 on Harbor Lane, two capsules of Omeprazole (anti ulcer drug) were left in the medication card and placed in the pile for discard on top of the medication cart. The pills remained on top of the medication cart throughout the medication pass. During an interview with RN #3, she indicated she did not see that there was medication in the card.</p>	F 0431	<p>The facility is unable to correct the alleged deficient practice.All residents have the potential to be affected by the alleged deficient practice.All nursing staff will be in-serviced regarding appropriate medication storage and presorting of medications.Nurse Managers will perform an audit of medication carts to ensure compliance 2 times weekly for 4 weeks, weekly times 2 months, then monthly ongoing.DON/designee to review nurse managers audits upon completion of each audit.Results of audits will be reviewed at QA meeting monthly ongoing.</p>	10/02/2015

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	<p>On 08/31/2015 at 8:21 a.m., during morning medication pass, one tablet of Gabapentin 600 mg (anticonvulsant medication) for Resident #184 was laying on top of the medication cart in the medication card. RN #3 was around the corner and indicated she was not aware there was medication in the medication card and left out.</p> <p>On 08/28/2015 at 8:40 a.m., during observation of the medication storage cart #1 on Willow Lane, an uncovered 30 ml medication cup containing a variety of pills with a resident's first name written on the outside, was observed to be in the right side top drawer. Two Ferrex 150 (iron supplement) capsules in their original manufacturers packages were in the right side top drawer of the medication cart. No patient label or pharmacy label was on the packaging.</p> <p>On 08/28/2015 at 08:45 a.m., Medication Cart # 2 of Willow Lane was observed. There were two uncovered 30 ml medication cups in the top right hand drawer with a resident's first name written on the outside of the cups. Each cup contained several pills.</p> <p>On 8/28/2015 at 10:30 a.m., during an interview with QMA #3, she indicated</p>			

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F 0441 SS=E Bldg. 00	<p>which residents that the cups belonged to and that she knew Depakote (mood stabilizer) was in one of the medication cups. She then indicated that she didn't know what other pills were in the cups because she does not normally work day shift or care for those residents. She indicated that the pills were "whatever pills were listed in the eMAR" and she indicated that what was listed in the eMAR was what she gave. She indicated she was in a hurry this morning and trying to give medication to these residents before they went to therapy and activities. That was why they were "presorted" into cups. QMA #3 indicated that she usually waited until it was time for medication to be given, to put the medication into a cup. She insisted she just happened to be observed during a time when these residents were leaving the unit for therapy and activities.</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to</p>			

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	<p>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to follow proper handwashing techniques during meal service. This practice has the potential to affect 17 of 17 residents that received their meals in the Memory Lane</p>	F 0441	The facility is unable to correct the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. Nursing and Housekeeping staff will be in-serviced regarding appropriate	10/02/2015			

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	<p>dining room. The facility failed to ensure linens were properly handled for 2 of 4 Units at the facility. This practice had the potential to affect 31 of 31 residents residing on the Fireside Court unit and 17 of 17 residents residing on the Memory Lane unit. (CNA #9, CNA #10, CNA #13, Laundry Aide #12)</p> <p>Findings include:</p> <p>1. On 08/24/2015 at 11:37 a.m., Certified Nurses Aide (CNA) #9, was observed carrying dirty linens against her clothing with no gloves on and disposing of them in the soiled utility room. CNA #9 made a resident's bed with clean linens without washing her hands or changing her soiled clothes.</p> <p>2. On 08/24/2015 at 12:10 p.m., CNA #9 was observed to wash her hands for 13 seconds during meal service on the Memory Lane Unit.</p> <p>On 08/24/2015 at 12:25 p.m., CNA #9 was observed to wash her hands for 8 seconds during meal service on the Memory Lane Unit.</p> <p>On 08/24/2015 at 12:29 p.m., CNA #10 was observed to wash her hands for 11 seconds during meal service on the Memory Lane Unit.</p>		<p>infection control policy and procedures regarding linen handling and hand washing. Nurse Managers and Housekeeping Supervisor to perform handwashing check offs and infection control observations related to linen handling 2 times weekly times 4 weeks, weekly times 2 months, then monthly ongoing. Results of hand washing check offs and infection control observations will be reviewed monthly at QA meetings ongoing.</p>				

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	<p>3. On 08/24/2015 at 1:07 p.m., a trash bag was observed sitting on the counter of the nurses station in Memory Lane. The trash bag contained straw paper, ice cream lids, soiled clear plastic wrap, empty milk cartons, papers containing resident name and meal description.</p> <p>4. On 08/24/2015 at 1:11 p.m., CNA #10 picked up dirty trays and was cleaning up the dining room when a resident dropped her fork onto her lap. CNA #10 then picked up the fork with her right hand, rinsed the fork under tap water, dried the fork with a paper towel and placed the fork back into the resident's hand after handling dirty trays and cleaning up.</p> <p>On 09/01/2015 at 8:37 a.m., during an interview with the infection control LPN, she indicated she did a handwashing inservice one time per year or as needed.</p> <p>On 09/01/2015 at 8:53 a.m., during an interview with CNA #9, she indicated that she washed her hands for at least 20 seconds after every activity she did with a resident.</p> <p>On 8/31/2015 at 3:51 p.m., the housekeeping manager provided guidelines for linen handling titled "Departmental (Environmental Services)</p>			

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	<p>- Laundry and Linen", which indicated "...2. Wash hands after handling soiled linens and before handling clean linen...3. Consider all soiled linen to be potentially infectious and handle with standard precautions...."</p> <p>5. On 8/25/15 at 8:05 a.m., during an observation of laundry delivery on the Fireside Unit, Laundry Aide #12 removed a hanger holding a pair of pants from the laundry cart and held them against her chest. She then bent down to reach a basket on the bottom of the cart, causing the pants to be folded between her chest and the tops of her legs. She then carried the clothing items to resident room #97. The laundry cart was left open and uncovered in the hallway. Laundry Aide #12 returned to the linen cart, removed hangers holding shirts, folded the shirts and hangers under her right arm and again reached into the basket on the bottom of the cart. She pulled the linen cart cover down with her left hand, partially covering the left side of the cart, and carried the clothing items into resident room #96. Laundry Aide #12 returned to the linen cart, removed hangers holding shirts, folded them under her right arm, and entered resident room #95.</p> <p>Laundry Aide #12 indicated she was aware the cart needed to be covered, but</p>			

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R 0000 Bldg. 00	<p>it was difficult to reach the cover on the top of the cart due to it's height. She further indicated she had to fold the clothing under her arm to keep it from touching the floor.</p> <p>On 8/25/15 at 2:45 p.m., CNA #13 was observed in the hallway on the Fireside Unit, holding a pile of linen containing a gown, towels, and washcloths in her left arm, against the side of her body. She then carried the linens to resident room # 93 and placed them on the bed near the window.</p> <p>On 9/1/15 at 9:43 a.m., a linen cart was observed to be uncovered in the shower room on the east hall of the Fireside Unit.</p> <p>3.1-18(l) 3.1-19(g)(1) 3.1-19(g)(2) 3.1-19(g)(3)</p> <p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.</p>	R 0000	The facility is unable to correct the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. QMA's and Nurses will be in-serviced regarding appropriate med storage,	

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R 0304 Bldg. 00	<p>Survey dates: August 24, 25, 26, 27, 28, 31 and September 1 and 2, 2015.</p> <p>Facility number: 000557 Provider number: 155455 AIM number: 100291240</p> <p>Census bed type: SNF: 13 SNF/NF:114 Residential:4 Total: 131</p> <p>Census payor type: Medicare: 13 Medicaid: 91 Other: 27 Total: 131</p> <p>Residential sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a</p>		specifically locking of the medication cart. Nurse Managers will perform an audit of medication carts to ensure compliance of medication storage and locking the medication carts 2 times weekly for 4 weeks, weekly times 2 months, then monthly ongoing. DON to conduct random audits 2 times weekly for 4 weeks, then monthly ongoing. Audits will be reviewed monthly at the QA meeting for compliance, ongoing.	

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	<p>substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation, interview and record review, the facility failed to properly lock the medication cart during medication pass. This had the potential to affect 4 of 4 residents living in the assisted living unit.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 9/1/2015 at 3:25 p.m., during observation of the medication pass for the resident in room 103, QMA #2 was observed walking away from the unlocked medication cart and into the resident room letting the door close behind her. The medication cart remained unlocked in the hallway for 4 minutes. On 9/1/2015 at 3:28 p.m., during an interview with QMA #2, while in room 103, she indicated that she had forgotten to lock her medication cart. On 9/1/2015 at 3:32 p.m., during an observation of medication pass, QMA #2 pushed the unlocked medication cart down to the Wesleyan Heights dining room to wash her hands. QMA #2 placed the unlocked medication cart in the hallway just before the doorway. The medication cart could not be observed 	R 0304	<p>The facility is unable to correct the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All nursing staff will be in-serviced regarding appropriate medication storage. Nurse managers will perform an audit of medication carts to ensure compliance 2 times weekly times 4 weeks, weekly times 2 months then monthly ongoing. DON/designee to review nurse managers audits upon completion of each audit. Results of audits will be reviewed at QA meeting monthly ongoing.</p>	10/02/2015

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	<p>from inside the dining room. The medication cart remained unlocked in the hallway for three minutes.</p> <p>On 9/1/2015 at 3:34 p.m., during an interview with QMA #2, she indicated that she knew she left the cart unlocked in the hallway and that she should have locked it.</p>				