

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/22/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00155592, IN00155844, IN00153982 and IN00153717.</p> <p>Complaint IN00155592- Substantiated. Federal deficiencies related to the allegations are cited at F441 and F520.</p> <p>Complaint IN00155844- Substantiated. Federal deficiencies related to the allegations are cited at F312.</p> <p>Complaint IN00153982- Substantiated. Federal deficiencies related to the allegations are cited at F312.</p> <p>Complaint IN00153717- Substantiated. Federal deficiencies related to the allegations are cited at F282 and F314.</p> <p>Survey dates: September 15, 16, 17, 18, 19 and 22, 2014.</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Survey team: Cynthia Stramel, RN-TC Lara Richards, RN</p>	F000000		

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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F000157 SS=D	<p>Heather Tuttle, RN Yolanda Love, RN</p> <p>Census bed type: SNF/NF: 165 Total: 165</p> <p>Census payor type: Medicare: 27 Medicaid: 124 Other: 14 Total: 165</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 25, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an</p>						

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	<p>existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to promptly notify the resident's family member before sending the resident out to the hospital for 1 of 1 residents reviewed for notification of change of the 1 resident who met the criteria for notification of change. (Resident #D)</p> <p>Findings include:</p> <p>Interview with Resident D's brother on 9/15/14 at 7:20 p.m., indicated the resident had a couple of falls and was sent out to the hospital for one of them and he was not contacted. He further indicated he was listed as the second emergency contact for the resident.</p>	F000157	<p>F157 The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident "D". Nurse educated on 9-22-14 to exhaust all potential contacts for a resident that has a significant change of condition.</p> <p>How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: Any resident with a significant change of condition has the potential to be affected by the alleged deficient practice. Residents with a significant change of condition were audited 9-23-14 to include appropriate family/POA notification for a</p>	10/22/2014

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	<p>The record for Resident #D was reviewed on 9/18/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, mental retardation.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated 7/24/14 indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident was rarely understood and was short tempered and easily annoyed.</p> <p>Review of Nurse's Notes dated 5/2/14 at 1:18 p.m., indicated the resident had fallen 11:45 a.m. At that time, the resident had complaints of pain in the right hip, head, and chest. The Physician was called and new orders to send the resident to the Emergency Room were obtained. The facility had a left a message for the family regarding the resident.</p> <p>Review of the resident's profile and face sheet indicated one brother was listed as the resident's Power of Attorney (POA) and first emergency contact. The resident's other brother was listed as the second emergency contact.</p> <p>Interview with the B Wing Unit Manager on 9/19/14 at 10:40 a.m., indicated she recalled the incident and was the</p>		<p>significant change of condition exhausting all potential contacts. Family/POA contacted if needed.</p> <p>Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Nursing staff to be in-serviced on October 15, 16, and 17th, 2014 regarding exhausting all potential contacts for a resident that has a significant change of condition. (exhibit # A) How the corrective action will be monitored to ensure the deficient practice does not recur : Audit created (exhibit # B): Audit to be completed by nursing supervisors/unit managers weekly x 8 weeks, then twice a month x 2 months, then monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>				

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	<p>supervisor on call that day. She indicated they did send the resident out to the hospital and called the resident's POA (emergency contact #1) and left a message. She indicated they did not speak to him just left a message. The Unit Manager further indicated they did not call or try to contact emergency contact #2 to let him know his brother was sent to the hospital.</p> <p>Review of the current and undated Notification of Change in Resident Health Status policy provided by RN #3 indicated, "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is an accident which results in injury and has the potential for requiring physician intervention."</p> <p>Interview with the Assistant Director of Nursing (ADON) on 9/19/14 at 1:00 p.m., indicated she would have expected the staff to try and get a hold of the second emergency contact if the nurses were sending the resident to the hospital. She further indicated this resident would need someone to accompany him to the hospital because of his disability.</p> <p>3.1-5(a)</p>						

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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview the facility failed to ensure prompt efforts by the facility to resolve a grievance were acted upon related to completing the grievance form for a missing cell phone for 1 of 2 residents reviewed for personal property of the 2 residents who met the criteria for personal property. (Resident #136)</p> <p>Findings include:</p> <p>Interview with Resident #136 on 9/15/14 at 3:03 p.m., indicated her cell phone came up missing over the weekend. She further indicated her daughter told the nurse that was working over the weekend. She indicated staff had not informed them they were still looking for her cell phone.</p> <p>Interview on 9/17/14 at 8:20 a.m., the resident indicated the facility had not found her cell phone. She further indicated her daughter had called the</p>	F000166	<p>F 166 Grievance The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident #136. Nursed educated on 9-22-14 regarding Grievance Guidelines.</p> <p>How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken:</p> <p>All residents have the potential to be affected by the alleged deficient practice. Grievances for the past month were reviewed to confirm any deficient practices were reviewed and corrected. Audit completed 10-3-14.</p> <p>Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: All Grievances will be reviewed in Morning Meeting and ED/DNS will follow up as needed with staff member assigned to specific grievances.Staff</p>	10/22/2014

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	<p>service provider and reported the phone lost and stolen.</p> <p>The record for Resident #136 was reviewed on 9/17/14 at 11:01 a.m.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated 9/10/14 indicated the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating the resident was alert and oriented.</p> <p>Review of the current 2013 Grievance Guideline policy provided by the Assistant Director of Nursing (ADON), indicated "All employees are responsible for ensuring customer satisfaction. When concerns arise, a grievance system is in place to resolve the issues to the satisfaction of all parties involved. Response to the grievance should be as soon as possible. Completing the form: The resident and/or family members or responsible people can complete the grievance form. If the resident or family does not want to complete the grievance form, it is the responsibility of the employee hearing the grievance to complete the form and submit it for follow up and resolution."</p> <p>Interview with the ADON on 9/18/14 at 1:15 p.m., indicated they got a hold of the</p>		<p>in-service scheduled on Oct 15, 16, and 17, 2014 on Grievance Guidelines and Grievance Form. (exhibit C)How the corrective action will be monitored to ensure the deficient practice does not recur Compliance to be monitored by QAPI committee Audit created (exhibit D) Audit to be completed by Social Service Director/designee weekly x 8 weeks, twice a month x 2 months, monthly x 4 months.</p> <p>Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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F000174 SS=D	<p>nurse who worked over the weekend. She indicated the nurse indicated the resident's daughter had informed her about the missing cell phone. The ADON indicated the nurse had thought the daughter was going to take care of the missing cell phone, therefore she did nothing about it. She indicated there was no complaint or grievance completed at that time. She indicated it was the facility's policy to complete a grievance form when there were complaints of missing items.</p> <p>3.1-7(a)(2)</p> <p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Based on observation, record review and interview, the facility failed to ensure a resident was provided privacy while making a telephone call for 1 of 3 residents reviewed for privacy of the 3 residents who met the criteria for privacy. (Resident #29)</p> <p>Findings include: Interview with Resident #29 on 9/15/14 at 3:26 p.m., indicated she had to use the</p>	F000174	F 174 Privacy The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice. Resident "29" was informed on 9-22-14 that staff will provide a private space for telephone calls. How other Residents having the potential to be affected by the same deficient practice were identified and corrective action	10/22/2014			

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	<p>telephone at the Nurses' station when she wanted to make a telephone call. She indicated that she was not aware of a private place to use the telephone.</p> <p>On 9/17/14 at 11:50 a.m., the resident was seated at the Nurses' station in her wheelchair using the phone. Other residents and staff were in the area at this time.</p> <p>The record for Resident #29 was reviewed on 9/17/14 at 10:07 a.m. The quarterly Minimum Data Set (MDS) assessment dated 8/21/14, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact.</p> <p>Review of the 12/5/13 annual MDS assessment, indicated it was very important for the resident to be able to use the phone in private.</p> <p>Interview with the C Wing Unit Manager on 9/19/14 at 3:20 p.m., indicated the facility no longer had a cordless phone and the residents were using the phone at the Nurses' station. She indicated if the resident's would want to make a private phone call, they could use her office.</p> <p>3.1-3(f)</p>		<p>was taken: Any resident that want to have a private conversation has the potential to be affected by the alleged deficient practice. Residents informed 10-2-14 of the right to a private space for telephone calls visitation. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Staff in-service 10-15, 16, 17, 2014 on "Residents' Rights" (exhibit #___E___) which includes "assisting residents in having access to private space for telephone calls and visitation without being overheard" Audit created (exhibit__F__) How the corrective action will be monitored to ensure the deficient practice does not recur : Audit to be completed by weekly by nursing supervisors/unit managers x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure all residents were free from physical restraints used to treat the resident's medical symptoms related to the use of a lap tray as an intervention after a fall for 1 of 3 residents reviewed for restraints of the 4 residents who met the criteria for restraints. (Resident #248)</p> <p>Findings include:</p> <p>On 9/16/14 at 3:25 p.m., Resident #248 was sitting up in a wheelchair across from the Nurse's station. The resident was dressed in street clothes and wearing shoes and socks to both of her feet. At that time, the resident had a lap tray across her wheelchair prohibiting the resident from standing up. The resident was not observed to be leaning forward or to the left or right side.</p> <p>On 9/17/14 at 9:00 a.m. and 12:45 a.m.,</p>	F000221	<p>F 221 restraints The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident 248. A restraint evaluation was completed for resident 248 on 9-22-14 How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: All Residents with restraints have the potential to be affected by the alleged deficient practice. Residents with restraints were audited on 9-22-14 for least restrictive restraint used. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Nurses to be in-serviced on 10-15, 16, 17, 2014 on "Restraint Evaluation and Utilization Guidelines" and "Pre-restraint evaluation." (exhibit</p>	10/22/2014			

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	<p>the resident was observed sitting up in wheelchair. At that time, the resident had a lap tray across her wheelchair prohibiting the resident from standing up. The resident was not observed to be leaning forward or to the left or right side.</p> <p>The record for Resident #248 was reviewed on 9/17/14 at 9:00 a.m. The resident was newly admitted to the facility on 9/3/14 from the hospital. The resident's diagnoses included, but was not limited to, fracture of pelvis, altered mental status, dementia, Alzheimer disease, anxiety, and hip fracture.</p> <p>Review of the Admission Minimum Data Set Assessment (MDS) assessment dated 9/10/14 indicated the resident was able to understand and her vision was highly impaired. The resident's Brief Interview for Mental Status score was a two, which indicated she was not alert and oriented. The resident had mood problems such as being short tempered and annoyed. The resident needed extensive two person assist for bed mobility and transfers. The resident had no impairments to her upper or lower extremities and used a wheelchair for primary locomotion. A restraint of the a chair that prevents rising was coded as being used less than daily. The resident had a history of a fall in the</p>		<p>G) How the corrective action will be monitored to ensure the deficient practice does not recur Compliance to be monitored by QAPI committee Audit created (Exhibit # H): Audit to be completed by nursing supervisors/unit managers weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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	<p>last month prior to admission. The resident also had a fracture prior to admission in the last six months. The resident was coded as having had one fall since admission with injury but not major.</p> <p>Review of Nurses Notes dated 9/7/14 at 8:30 a.m., indicated the resident was seated in her wheelchair by the med cart at the Nurse's station. The resident was observed leaning forward and turned her shoe around and fell forward and hit the left side of her forehead on the ground. The resident was alert and was talking to staff. She obtained a .5 centimeter (cm) by .3 cm laceration to the left side of her forehead. The Physician was notified and a new order was obtained to send the resident to the hospital.</p> <p>Further review of Nurse's Notes dated 9/7/14, at 3:00 p.m., indicated the resident returned from hospital with sutures to her forehead. At that time, nursing staff placed a lap tray to the resident's wheelchair. The family was made aware and signed the consent form for the restraint.</p> <p>Continued review of Nursing Progress Notes dated 9/3-9/6/14 prior to the fall indicated there was no documentation the resident attempted to stand alone, was</p>			

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	<p>leaning forward from the wheelchair, or to the side in the wheelchair. There was no evidence of any documentation the resident was anxious or upset that she was moving around in her wheelchair and was attempting to stand by herself.</p> <p>Nurse's Notes dated 9/8/14 at 9:28 a.m. indicated the Interdisciplinary Team (IDT) met and discussed the residents fall on 9/7/14. The interventions were reviewed. The IDT considered a self release belt but the resident was unable to release on demand, therefore, a lap tray was applied and therapy to evaluate for the least restrictive measure.</p> <p>Review of the current 9/8/14 care plan indicated the resident was at risk for injury related to a physical restraint due to lap tray to wheelchair while up. Nursing approaches were to check every hour and release, complete appropriate restraint and/or side rail assessment per living center, educate family regarding risk of restraint, and reassess for potential reduction.</p> <p>Review of the current 2013 Restraint Evaluation and Utilization Guideline Policy provided by the Assistant Director of Nursing indicated, "A restraint will not be applied to purposes of discipline or convenience or when not required to treat</p>			

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	<p>the resident's medical symptoms. The least restrictive device will be used."</p> <p>Interview with the C Wing Unit Manager on 9/17/14 at 2:10 p.m., indicated the lap tray, body pillow and floor mats were put into place after the resident had fallen on 9/7/14. She indicated she was informed the resident bent over to pick something up and fell forward from the wheelchair. She further indicated the family wanted the resident to wear a belt but did indicate a lap tray was ok. She indicated the resident had only fallen one time since admission.</p> <p>Interview with the B Wing Unit Manager on 9/17/14 at 2:40 p.m., indicated she was on call manager over that weekend when the resident had fallen. She indicated the resident bent down and was touching her shoe and was leaning forward. The resident then started to fall and the nurse who was standing right next to her tried to stop the fall, but the resident fell forward and hit her face on the floor. The B Wing Unit Manager indicated when she came back the family wanted the facility to restrain the resident and put a belt around her, but they put the lap tray on her instead. She further indicated the facility immediately placed a lap tray on the resident and there were no other least restrictive measures tried</p>				

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F000241 SS=D	<p>first after the resident had fallen.</p> <p>3.1-26(o)</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 and interview, the facility failed to ensure each residents' dignity was maintained related to dressing and not being called by their name for 2 of 3 residents reviewed for dignity of the 6 who met the criteria for dignity. (Residents #F and #42)</p> <p>Findings include:</p> <p>1. On 9/16/14 at 12:36 p.m. and 3:25 p.m., Resident #F was observed in her room in bed wearing a hospital gown.</p> <p>On 9/17/14 at 9:10 a.m., 10:59 a.m., 2:22 p.m., and 3:25 p.m., the resident was in her room in bed. The resident was awake and wearing a hospital gown.</p> <p>On 9/18/14 at 9:10 a.m., the resident was</p>	F000241	<p>F 241 Dignity The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident F and 42. Resident F was put in a housecoat. Staff caring for resident F and 42 were immediately educated on resident dignity. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: All residents that need assistance and are not alert and oriented have the potential to be affected by the alleged deficient practice. Audit completed on 9-19-14 regarding resident clothing preferences and being addressed by names other</p>	10/22/2014

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	<p>in her room in bed wearing a hospital gown.</p> <p>On 9/19/14 at 10:06 a.m., morning care was observed for the resident. After the completion of care, the resident was provided a hospital gown. Observation of the resident's closet at this time, indicated the resident had several different housecoats.</p> <p>Interview with the resident's sisters on 9/18/14 at 1:10 p.m., indicated the resident had "dusters" in her closet and they would like her to wear one every now and then over her hospital gown.</p> <p>Interview with the C Wing Unit Manager on 9/19/14 at 3:20 p.m., indicated that she would instruct the CNA's to offer the resident her housecoat.</p> <p>2. On 9/17/14 at 1:35 p.m., Resident #42 was observed sitting in his wheelchair across from the Nurse's station. At that time, CNA #1 came up to the resident and indicated "Hey Donald Duck can you wake up for me?" The resident looked up at the CNA and just kept repeating over and over again "Amen, Amen, Amen,"</p> <p>The record for Resident #42 was reviewed on 9/19/14 at 10:16 a.m. The resident's diagnoses included, but were</p>		<p>than their given/preferred name. Clothing changed per preference and care planned if needed. Resident with a preferred name other than given name were care planned. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Staff to be in-serviced on 10-15, 16, 17, 2014 regarding resident rights focusing on dignity. (exhibit #____)</p> <p>How the corrective action will be monitored to ensure the deficient practice does not recur Compliance to be monitored by QAPI committee Audit created (Exhibit #J): Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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F000272 SS=D	<p>not limited to, anxiety disorder, dementia with behavioral disturbances, and presenile dementia.</p> <p>Review of the Quarterly Minimum Data Set assessment dated 8/28/14 indicated the resident was not alert and oriented.</p> <p>Review of the current 8/2014 updated care plan indicated the resident had the diagnoses of presenile dementia due to cognitive loss, and had diminished decision making capabilities. The Nursing approaches were to provide environmental cues of pictures in memory box and personalized room to minimize effects of cognitive deficits.</p> <p>Further review of the current plan of care indicated there was no evidence of any care plan the resident wanted to be called any other name other than his own name.</p> <p>Interview with the B Wing Unit Manager on 9/18 14 at 2:30 p.m., indicated calling the resident Donald Duck was not acceptable.</p> <p>3.1-3(t)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of</p>			

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	<p>each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure restraint assessments were completed related to the use of lap trays that the residents were not able to release on command for 3 of 3 residents reviewed for restraints of the 4 residents who met the criteria for restraints. (Residents #88, #169, and #248)</p>	F000272	F 272 restraints The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident 88, 169 and 248. A restraint evaluation was completed for resident 88, 169 and 248 on 9-22-14 How other Residents having the potential	10/22/2014

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	<p>Findings include:</p> <p>1. The record for Resident #88 was reviewed on 9/17/14 at 9:45 a.m. The resident's diagnoses included, but were not limited to, peripheral neuropathy, personal history of fall, head injury on 5/6/14, fall, presenile dementia, episodic mood disorder, and anxiety disorder.</p> <p>Review of Physician Orders dated 5/20/14 indicated to check placement and function of lap tray for positioning while in wheelchair. Check one hour and release every 2 hours. Release while eating.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated 8/29/14 indicated the resident was able to understand and be understood. The resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating she was alert and oriented. The resident had a restraint of a chair that prevents rising in which it was used daily.</p> <p>Continued record review indicated there was no evidence of a restraint assessment for the lap tray restraint.</p> <p>Interview on 9/19/14 at 3:00 p.m., with the C Wing Unit Manager indicated there</p>		<p>to be affected by the same alleged deficient practice were identified and corrective action was taken: All Residents with restraints have the potential to be affected by the alleged deficient practice. Residents with restraints were audit on 9-22-14 and evaluation completed per policy. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Nurses to be in-serviced on 10-15, 16, 17, 2014 on "Restraint Evaluation and Utilization Guidelines" and "Pre-restraint evaluation." (exhibit G) How the corrective action will be monitored to ensure the deficient practice does not recur Compliance to be monitored by QAPI committee Audit created (Exhibit H): Audit to be completed by nursing supervisors/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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	<p>was no other restraint assessment for the resident.</p> <p>2. The record for Resident #248 was reviewed on 9/17/14 at 9:00 a.m. The resident was newly admitted to the facility on 9/3/14 from the hospital. The resident's diagnoses included, but not limited to, fracture of pelvis, altered mental status, dementia, Alzheimer disease, anxiety, and hip fracture.</p> <p>Review of Physician's Orders dated 9/7/14 indicated lap tray for positioning while in wheelchair. Check every hour and release every two hours.</p> <p>Review of the Admission Minimum Data Set Assessment (MDS) assessment dated 9/10/14 indicated the resident was able to understand and her vision was highly impaired. The resident's Brief Interview for Mental Status score was a two, which indicated she was not alert and oriented. The resident had mood problems such as being short tempered and annoyed. The resident needed extensive two person assist for bed mobility and transfers. The resident had no impairments to her upper or lower extremities and used a wheelchair for primary locomotion. A restraint of the a chair that prevents rising was coded as being used less than daily. The resident had a history of a fall in the</p>			

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	<p>last month prior to admission. The resident also had a fracture prior to admission in the last six months. The resident was coded as having had one fall since admission with injury but not major.</p> <p>Review of the current 9/8/14 care plan indicated the resident was at risk for injury related to a physical restraint due to lap tray to wheelchair while up. Nursing approaches were to check every hour and release, complete appropriate restraint and/or side rail assessment per living center, educate family regarding risk of restraint, and reassess for potential reduction.</p> <p>Continued record review indicated there was no evidence of a restraint assessment for the lap tray restraint.</p> <p>Interview with the B Wing Unit Manager on 9/17/14 at 2:40 p.m., indicated there was no restraint assessment completed for the resident.</p> <p>Interview with the Assistant Director of Nursing on 9/17/14 at 2:56 p.m., indicated Nursing did not complete restraint assessments.</p> <p>Review of the current 2013 Restraint Evaluation and Utilization Guideline</p>			

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	<p>provided by the Assistant Director of Nursing indicated "Residents who have physical restraints are to be reevaluated quarterly or more often as directed by the needs of the resident..."</p> <p>3. The record for Resident #169 was reviewed on 9/17/14 at 12:45 p.m. The resident's diagnoses included, but were not limited to, dementia with behaviors and epilepsy with convulsions.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 3/9/14 indicated the resident had severe cognitive impairment, had a history of falls prior to admission and required extensive assistance for transferring and bed mobility.</p> <p>A Physician's order dated 4/16/14 indicated the resident to have padded lap tray when up in chair.</p> <p>The Quarterly Resident Assessment dated 9/17/18 indicated the resident's fall score was 18, any score over 10 was a high risk of falls. Interventions were listed as side rails and, "other device". The form indicated, "if yes, complete appropriate assessment".</p> <p>Interview with the Unit Manager at 3:15 p.m. on 9/18/14, indicated she had done the Quarterly Resident Assessment the</p>			

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F000282 SS=D	<p>previous day. She indicated she had completed the side rail assessment, but did not do an assessment related to the lap tray.</p> <p>Interview with MDS Coordinator on 9/19/14 at 11:28 a.m., indicated there were no assessments for the lap tray available for review.</p> <p>3.1-31(a)</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, record review and interview, the facility failed to ensure Physician's orders were followed as written related to the use of a wound vacuum for 1 of 3 residents reviewed for pressure ulcers of the 3 residents who met the criteria for pressure ulcers. (Resident #F)</p> <p>Findings include:</p> <p>On 9/17/14 at 2:22 p.m., Resident #F was observed in her room in bed. The resident's wound vacuum was positioned on the dresser next to the resident's bed. The screen on the wound vacuum was</p>	F000282	F 282 Services by qualified persons/per care plan/following physician orders The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident F. Resident F with wound vac was audited to verify that the wound vac was in use as physician ordered. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: Any Resident that have physician orders for a wound vac has the	10/22/2014			

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	<p>dark. When asked if the wound vacuum was on, LPN #4 proceeded to the dresser and pushed the button on the wound vacuum, she indicated the wound vacuum was not on. She restarted the wound vacuum at this time.</p> <p>The record for Resident #F was reviewed on 9/17/14 at 2:44 p.m. The resident's diagnoses included, but were not limited to, pressure ulcer to buttock, pressure ulcer to heel, pressure ulcer unstageable, and pressure ulcer stage 4.</p> <p>A Physician's order dated 8/30/14, indicated to maintain the wound vacuum continuous at 125 mm/Hg (millimeters of mercury) every shift.</p> <p>Review of the current plan of care, indicated the resident had a pressure ulcer. The interventions included, but were not limited to, treat as ordered.</p> <p>Interview with the resident's sister on 9/18/14 at 1:10 p.m., indicated when she was visiting on 9/17/14 at 1:00 p.m., the resident's wound vacuum was alarming and staff were supposed to notify the Wound Nurse. She indicated that when she left at approximately 1:30 p.m., the resident's wound vacuum was not on.</p> <p>Interview with the Assistant Director of</p>		<p>potential to be affected by the alleged deficient practice. Nurses caring for residents with a wound vac were educated on following physician orders for wound vac. 9-17-14 . Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: All nurses to be in-serviced on 10-15, 16, 17, 2014 on following physician orders for anyone that has a physician order for a wound vac. (Exhibit K)How the corrective action will be monitored to ensure the deficient practice does not recur : Audit created (Exhibit #L): Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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F000309 SS=D	<p>Nursing on 9/19/14 at 3:00 p.m., indicated the resident's wound vacuum should not have been turned off.</p> <p>This Federal tag refers to Complaint IN00153717.</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> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services related to monitoring and assessing bruising for 1 of 4 residents reviewed for non-pressure related skin conditions of the 7 residents who met the criteria. (Resident #247)</p> <p>Findings include:</p> <p>On 9/15/14 at 2:53 p.m., Resident #247 was observed lying in bed in his room. At that time, he was observed to have two large purple bruises on his right arm.</p>	F000309	<p>F309 Bruises The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident #247. On head to toe assessment completed on resident 247 - non decub wound sheets completed.</p> <p>How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: Any new admission or readmission has the potential to be affected by the alleged deficient practice. New admissions/readmissions skin to</p>	10/22/2014

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	<p>The record for Resident #247 was reviewed on 9/18/14 at 10:15 a.m. The resident was admitted to the facility on 9/7/14; he was discharged to the hospital on 9/12/14, and readmitted to the facility on 9/14/14. The resident's diagnoses included, but were not limited to, pain, diabetes, and a pacemaker.</p> <p>Review of the wound evaluation flow sheets dated 9/7/14, indicated black and blue discolorations to the resident's right antecubital (the region of the arm in front of the elbow) measuring 6 centimeters (cm) by 6 centimeters (cm) and a second discoloration on the side of that bruise measuring 6 cm x 4 cm. There was no further documentation of monitoring of the bruising noted on the wound evaluation flow sheets.</p> <p>Interview with LPN #3 on 9/18/14 at 9:44 a.m., indicated during the admission assessment on 9/7/14 the resident was noted to have bruising to his right arm which was documented on the wound evaluation flow sheet. She further indicated the resident was discharged from the facility on 9/12/14 and readmitted on 9/14/14. There was no documentation on 9/14/14 indicating bruising to the right arm. At that time an assessment of the resident's right arm was observed.</p>		<p>be assessment by 2 nurses. for 6 months or until compliance is reached. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Staff to be in-serviced on 10-15, 16, 17, 2014 regarding Skin Assessment procedure. (exhibit M)Audit created How the corrective action will be monitored to ensure the deficient practice does not recur Compliance to be monitored by QAPI committee Audit created (Exhibit N) Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>	

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F000311 SS=D	<p>LPN #3 indicated the resident had two purple bruises to his right arm measuring 5 cm x 3 cm and 3 cm x 5 cm, and the bruising should have been assessed on admission and monitored until healed.</p> <p>Review of the Skin Care Protocol dated June 2014, received from RN #1 on 9/19/14 at 9:51 a.m., indicated, "Evaluation/observation is to be completed within the first twenty-four hours of admission..."</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, record review, and interview, the facility failed to ensure each resident received the necessary services to maintain good grooming related to providing assistance with showers, dressing, and grooming for 1 of 4 residents reviewed for Activities of Daily Living (ADL's). (Resident #155)</p> <p>Findings include:</p>	F000311	<p>F 311 TX/Services to improve/maintain ADLs The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident #155. Resident showered and clothing changed on 9-18-14. How other Residents having the potential to be affected by the same alleged deficient practice</p>	10/22/2014	

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	<p>On 9/15/14 at 3:10 p.m., Resident # 155 was observed in her room seated in her recliner. The resident was wearing a white camisole, a beige shirt, a pink button-up sweater, red jogging pants, and white socks with black shoes.</p> <p>On 9/16/14 at 10:10 a.m., Resident #155 was observed in her room sleeping in her recliner. The resident was wearing a white camisole, a beige shirt, a pink button-up sweater, red jogging pants, and white socks with black shoes.</p> <p>On 9/17/14 at 9:09 a.m., Resident #155 was observed in her room sleeping in her recliner. The resident was wearing a white camisole, a beige shirt, a pink button-up sweater, red jogging pants, and white socks with black shoes.</p> <p>On 9/17/14 at 11:43 a.m., Resident #155 was observed being wheeled to the dining room, she was wearing a white camisole, a beige shirt, a pink button-up sweater, red jogging pants, and white socks with black shoes.</p> <p>On 9/17/14 at 2:40 p.m., Resident #155 was observed in her room sleeping in her recliner. The resident was wearing a white camisole, a beige shirt, a pink button-up sweater, red jogging pants, and white socks with black shoes.</p>		<p>were identified and corrective action was taken: All residents that need assistance and are not alert and oriented have the potential to be affected by the alleged deficient practice. Shower sheets audited and residents in dirty clothing audited. Residents given showers if needed and clothing changed if dirty. Audit completed on 9-22-14</p> <p>Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Nursing to be in-serviced on October 15, 16, 17, 2014 regarding resident showers and clean clothing for Treatment/Services to improve/maintain ADLs. (exhibit O and P) Audit created How the corrective action will be monitored to ensure the deficient practice does not recur Compliance to be monitored by QAPI committee Audit created (Exhibit Q): Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>	

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	<p>On 9/18/14 at 2:30 a.m., the resident was again observed in her room sleeping in her recliner. The resident was wearing a white camisole, a beige shirt, a pink button-up sweater, red jogging pants, and white socks with black shoes. The resident's bed was still made.</p> <p>The record for Resident # 155 was reviewed on 9/17/14 at 9:15 a.m. The resident's diagnoses included, but were not limited to, impaired mobility and impaired vision related to macular degeneration.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 8/5/14 indicated the resident's vision was severely impaired, she required limited one person assistance with dressing and personal hygiene, and was total dependence with bathing. The resident had no rejection of care behaviors.</p> <p>Review of the September 2014 weekly skin check shower sheets indicated the resident was to be showered on Tuesday and Friday evenings. Further review also indicated the resident had not been showered since 9/12/14.</p> <p>A care plan dated 12/2/2013 indicated the resident was visually impaired related to</p>			

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	<p>macular degeneration, interventions included, but were not limited to; provide set up and cueing as necessary.</p> <p>Interview with the resident on 9/17/14 at 9:26 a.m., indicated she was to be showered on Tuesday and Friday. When asked if she had a shower on Tuesday (9/16/14) she indicated she did not remember. When asked if she knew she was wearing the same clothes since Monday (9/15/14) she indicated was not aware.</p> <p>Interview with CNA #9 on 9/18/14 at 2:43 a.m., indicated she had been the resident's CNA for the past few nights and she was unsure if the resident had been showered on 9/16/14, and when asked if she noticed the resident had not had a change in clothing since 9/15/14 she failed to confirm or deny.</p> <p>Interview with the Unit Manager on 9/22/14 at 11:10 a.m., indicated it was her expectation for staff to assist residents with dressing and grooming. She further indicated it was her expectation for residents to be showered on their scheduled shower days. Staff was in-serviced on showering residents and proper documentation on 8/21/14.</p> <p>3.1-38(a)(3)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident who was dependent on Activities of Daily Living (ADL'S) received the necessary treatment and services related to urinary incontinence and showers for 2 of 3 residents reviewed for ADL'S of the 3 who met the criteria for ADL'S. (Residents #D and #E)</p> <p>Findings include:</p> <p>1. Interview with Resident #D's brother on 9/15/14 at 7:12 p.m., indicated he had concerns his brother does not get the toileting help he needs. The resident's brother indicated there had been many times when the resident was "sopping wet" with urine including shoes and socks.</p> <p>On 9/17/14 at 8:30 a.m., the resident was observed sitting in his wheelchair and seated at a table in the dining room eating his breakfast.</p>	F000312	<p>F 312 ADL care for dependent res. The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident D. Resident was toileted and ADL care performed 9-17-14. Unable to correct the alleged deficient practice for resident E. Resident was showered and hair combed on 9-17-14. observed 9 -17-14)</p> <p>How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: All residents that need assistance for ADL's are at risk for the alleged deficient practice. Audit completed for residents that need assist for ADL's were audited on 9-22-14, Residents were toileted if needed or according to toileting plan and hair brushed/combed if needed. Measures that were put in place or what systemic change to ensure that the deficient practice does not</p>	10/22/2014	

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	<p>On 9/17/14 at 8:45 a.m., the resident was assisted out of the dining room to the edge of the hallway toward his wing where his room was. At that time, he was directed into the Activity room by an Activity Assistant where many residents were being gathered after breakfast.</p> <p>Observation continued from 8:45 a.m. until 11:00 a.m. and the resident still remained in the Activity room. During that time, there was no staff member that assisted the resident to the bathroom or checked him for incontinence.</p> <p>On 9/17/14 at 11:20 a.m., the resident's twin brother came up to the nurses station and made a short visit with the resident while he was in the Activity room.</p> <p>On 9/17/14 at 11:45 a.m. the resident was assisted out of the Activity room and placed in the dining room at his table for lunch.</p> <p>On 9/17/14 at 12:00 p.m., the resident was observed at his table in the dining room waiting on lunch. During that time, no staff had made any attempts to change or check him for incontinence</p> <p>On 9/17/14 at 12:45 p.m., the resident was still observed in dining room eating lunch.</p>		<p>recur: Nursing to be in-serviced on October 15, 16, 17, 2014 regarding resident ADL's. (exhibit O, S and P) Audit created How the corrective action will be monitored to ensure the deficient practice does not recur Compliance to be monitored by QAPI committee Audit created (Exhibit Q): Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>				

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	<p>On 9/17/14 at 12:57 p.m., the resident was observed propelling himself back to the unit in his wheelchair.</p> <p>On 9/17/14 at 1:20 p.m., LPN #2 who was observed standing by her medication cart indicated to the resident that she would take him to activities and the resident agreed to go. At that time, the Unit Manager was asked to check the resident for incontinence. The Unit Manager indicated the resident's CNA had stayed over from the midnight shift and had left for the day at 1:00 p.m.</p> <p>CNA #6 was then asked to take the resident to the bathroom and check him for incontinence. The CNA wheeled the resident into his room and to the bathroom. The resident stood up and the CNA removed his pants and incontinent brief. At that time, the brief was saturated with urine. The CNA indicated he had not taken the resident to the toilet all day, because he was on a different hall. The CNA indicated the resident was on the early get up list, so he had been up this morning before 6:00 a.m.</p> <p>The record for Resident #D was reviewed on 9/18/14 at 9:00 a.m. The resident's diagnoses included, but were not limited mental retardation.</p>			

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	<p>Review of the Annual Minimum Data Set (MDS) assessment dated 7/24/14 indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident was rarely understood and was short tempered and easily annoyed. The resident needed extensive assist with one person physical assist with bed mobility, transfers, toilet use, dressing and personal hygiene, The resident was not on a toileting program and was frequently incontinent of bladder.</p> <p>Review of the early morning get up list in which the midnight CNAs get the residents up indicated Resident #D was on that list. The midnight shift CNAs end their shift at 6:00 a.m., therefore, the resident was up and dressed in his wheelchair by 6:00 a.m.</p> <p>Interview with the B Wing Unit Manager on 9/17/14 at 1:30 p.m., indicated the resident should have been checked and changed every two hours. She further indicated staff were to remove residents from activities briefly to check and change them for incontinence.</p> <p>Interview with LPN #2 on 9/17/14 at 1:40 p.m., indicated she does not usually toilet the resident unless they were short</p>			

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	<p>of help, nor did she toilet the resident today.</p> <p>Interview with CNA #5 on 9/17/14 at 1:45 p.m., indicated she did not toilet the resident that day, she indicated another CNA was the resident's aide that day.</p> <p>2. On 9/17/14 at 8:46 a.m., Resident #E was observed seated in front of the nursing station in her wheelchair sleeping. She was dressed appropriately for the weather and her hair was noted to be frizzy and in French braids.</p> <p>On 9/22/14 at 9:10 a.m., the resident was observed seated in front of the nursing station with a hat on her head, her hair was noted to be frizzy. An interview with the resident at the time indicated she had not had her faced washed, teeth brushed, or her hair combed that morning.</p> <p>The record for Resident #E was reviewed on 9/17/14 at 10:10 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, psychiatric disorder with delusions, below the knee amputation, diabetes, macular wasting and disuse atrophy.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 6/12/14 indicated, the resident required extensive</p>				

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	<p>two person assistance with transfers, extensive one person assistance with dressing and personal hygiene, and was totally dependent with bathing. The resident had no rejection of care behaviors.</p> <p>Review of the September 2014 weekly skin check shower sheets indicated the resident was to be showered on Monday and Thursday evenings. Further review also indicated no evidence of documentation of the resident being given a shower for the month.</p> <p>Review of the CNA bathing type detail sheets dated 8/23/14 through 9/22/14 indicated the resident had only been given two showers, on 9/8/14 and 9/15/14.</p> <p>Interview with the resident's spouse on 9/17/14 at 9:04 a.m., indicated the staff never brushes the resident's teeth when they get her up in the morning.</p> <p>Interview with CNA #8 on 9/22/14 at 9:26 a.m., indicated she did not provide any ADL care for the resident that morning; she had only repositioned the resident in her wheelchair. She further indicated the facility staff did not comb the resident's hair; the resident's daughter combs her hair.</p>			

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F000314 SS=D	<p>Interview with the Unit Manager on 9/22/14 at 11:10 a.m., indicated there were no nursing notes documenting the resident had refused her showers or morning ADL care. Further interview also indicated, it was her expectation for staff to assist residents with dressing and grooming. She further indicated it was her expectation for resident's to be showered on their scheduled shower days. Staff was in-serviced on showering residents and proper documentation on 8/21/14.</p> <p>This Federal tag relates to Complaint IN00153982 and Complaint IN00155844.</p> <p>3.1-38(a)(3) 3.1-38(a)(3)(B) 3.1-38(a)(3)(E)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>			
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	<p>Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided to promote healing of a pressure sore related to the use of a wound vacuum for 1 of 3 residents reviewed for pressure ulcers of the 3 residents who met the criteria for pressure ulcers. (Resident #F)</p> <p>Findings include:</p> <p>On 9/17/14 at 2:22 p.m., Resident #F was observed in her room in bed. The resident's wound vacuum was positioned on the dresser next to the resident's bed. The screen on the wound vacuum was dark. When asked if the wound vacuum was on, LPN #4 proceeded to the dresser and pushed the button on the wound vacuum, she indicated the wound vacuum was not on. She restarted the wound vacuum at this time.</p> <p>The record for Resident #F was reviewed on 9/17/14 at 2:44 p.m. The resident's diagnoses included, but were not limited to, pressure ulcer to buttock, pressure ulcer to heel, pressure ulcer unstageable, and pressure ulcer stage 4.</p> <p>A Physician's order dated 8/30/14, indicated to maintain the wound vacuum continuous at 125 mm/Hg (millimeters of</p>	F000314	<p>F 314 tx to prevent/heal pressure ulcers The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident F. Resident F with wound vac was audited to verify that the wound vac was in use as physician ordered. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: Any Resident that have physician orders for a wound vac has the potential to be affected by the alleged deficient practice. Residents with wound vacs ordered were audited 9-17-14 for following physician order. Nurses caring for residents with a wound vac were educated on following physician orders and "Skin Integrity Guidelines" on 9-17-14 (exhibit K and KK)Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: All nurses to be in-serviced on 10-15, 16, 17, 2014 on following physician orders for anyone that has a physician order for a wound vac. Audit created How the corrective action will be monitored to ensure the deficient practice does not recur : Audit created (Exhibit #</p>	10/22/2014			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>mercury) every shift.</p> <p>Review of the current plan of care, indicated the resident had a pressure ulcer. The interventions included, but were not limited to, treat as ordered.</p> <p>Review of the Wound Evaluation flow sheet dated 9/17/14, indicated the resident had a Stage 4 wound to her left buttock. The area measured 9.5 centimeters (cm) x 9 cm x 2.5 cm. The area required the use of a wound vacuum. Documentation also indicated the wound had recently been debrided at the Wound Clinic.</p> <p>Interview with the resident's sister on 9/18/14 at 1:10 p.m., indicated when she was visiting on 9/17/14 at 1:00 p.m., the resident's wound vacuum was alarming and staff were supposed to notify the Wound Nurse. She indicated that when she left at approximately 1:30 p.m., the resident's wound vacuum was not on.</p> <p>Interview with the Assistant Director of Nursing on 9/19/14 at 3:00 p.m., indicated the resident's wound vacuum should not have been turned off.</p> <p>This Federal tag refers to Complaint IN00153717.</p>		<p>L): Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months.</p> <p>Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>				

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F000364 SS=D	<p>3.1-40(a)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to serve food at a warm temperature for 1 of 2 meals observed. (The Breakfast meal and Resident #136)</p> <p>Findings include:</p> <p>1. On 9/18/14 at 8:33 a.m., the room trays arrived to the B Wing. At that time, there were three facility staff members passing the trays.</p> <p>At 8:47 a.m., the last tray was passed and the temperatures of the food from the test tray on the cart were obtained by the Dietary Food Manager.</p> <p>Continued observation indicated the ceramic plate was covered with a plastic thermal lid as well as a bottom.</p> <p>The fried eggs were 91 degrees Fahrenheit, the hash browns were 108 degrees and the oatmeal was 145 degrees.</p>	F000364	<p>F 364 Palatable/Prefer Temp The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice. Staff educated proper holding temps for food on the steam table. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: Any resident that eats eggs have the potential to be affected by the alleged deficient practice. Staff educated on proper holding temps for food on the steam table. Plate lowerator/warmer was not working properly. Repaired on 9-26-14. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Staff to be in-serviced on 10-13-14 to make sure the indicator lowerator/warmer is working properly and to hold fried eggs in hot water to keep</p>	10/22/2014

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	<p>Interview with the Dietary Food Manager at that time, indicated the fried egg as well as the hash browns were too cold. She further indicated she takes food temperatures from random test trays at least once a week on each unit.</p> <p>Review of her temperature logs from the last two weeks indicated there were times when the eggs were recorded at 116 and 118 degrees. The pancakes were also recorded as being 118 degrees.</p> <p>2. On 9/15/14 at 3:04 p.m., Resident #136 was interviewed. At that time, she indicated she eats in the main dining room and sometimes eats in her room. She indicated breakfast was always cold especially the eggs.</p> <p>On 9/17/14 at 8:20 a.m., the resident was up and dressed and seated in the main dining room eating breakfast. She indicated the food was ok, "but it was cold as usual."</p> <p>On 9/18/14 at 8:50 a.m., the resident was walking back to her room from the main dining room after eating breakfast. She indicated the fried eggs were cold.</p> <p>3.1-21(a)(2)</p>		<p>acceptable temperature. (exhibit 1A) Will continue weekly spot checks and audit temp logs in the kitchen. How the corrective action will be monitored to ensure the deficient practice does not recur: Audit created (Exhibit #__1B): Audit to be completed by dietary manager/dietary supervisor weekly x 8 weeks, twice a month x 2 months, monthly x 4 months.</p> <p>Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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F000371 SS=E	<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 store and prepare food under sanitary conditions related hand washing, the use of clean gloves, food crumbs on the steam table, and dirty transportation cart covers for 1 of 1 kitchens observed. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Sanitation tour on 9/15/14 9:10 a.m., the following was observed:</p> <p>A. There were three tall transportation racks with dirty plastic covers. There was dried food substance observed on the outside of the plastic covers. The racks were also dirty with dried food spillage. The wheels were also noted to be greasy and dirty.</p> <p>B. There were dead insects noted on the</p>	F000371	<p>F 371 dietary The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice Unable to correct the alleged deficient practice. Dirty plastic covers cleaned on 9-15-14. Window ledge cleaned on 9-15-14. 9-18-14 cook educated on infection control. 9-19-14 screen above the stove was cleaned, food crumbs cleaned from steam table, convection oven cleaned, baseboard cleaned, and floors cleaned. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken. All residents have the potential to be affected by the alleged deficient practice. All plastic covers and window ledges audited and cleaned if necessary on 9-18-14. All screens, steams tables, convection oven, baseboard and floors were audited and cleaned on 9-19-14.</p>	10/22/2014

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	<p>window ledge where clean dishes were drying. The window fan had a heavy accumulation of black dirt and dust noted on the blades and slats. The fan was blowing directly on the clean dishes.</p> <p>2. On 9/18/14 at 7:05 a.m., Dietary Cook #1 was observed standing by the toaster and touching the uncooked bread with her bare hands. At that time, she immediately left that area and walked over to a box of disposal gloves and placed a pair on her hands. She did not wash her hands before donning the gloves. She then walked back over to the toaster and began picking up the bread with her gloved hands and placing it in the toaster. She was then observed to touch plates, utensils, lids, and a rack of bowls with the same gloved hands. She did not change her gloves during this time. She was then observed to touch the toasted bread and place it into a pan on the steam table.</p> <p>Continued observation indicated the cook removed her gloves and began to take temperatures of the food on the steam table. Again she had not washed her hands with soap and water. The temperature of all the food was obtained. The fried eggs were 137 degrees Fahrenheit. Both dietary cooks began serving and plating the resident's food for</p>		<p>Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Dietary staff to be in-serviced on 10-13-14 on infection control and cleaning procedures. (Exhibit U and 1A) Audit created. How the corrective action will be monitored to ensure the deficient practice does not recur Audit created (Exhibit 1B): Audit to be completed by dietary manager/dietary supervisor weekly x 8 weeks, twice a month x 2 months, monthly x 4 months.</p> <p>Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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	<p>the E wing.</p> <p>Interview with Dietary Cook #1 on 9/18/14 at 7:45 a.m., indicated she was aware she was not supposed to touch the food with her bare hands. She further indicated she was aware when wearing gloves she could touch the food and nothing else.</p> <p>Interview with the Dietary Food Manager at the time, indicated she discourages her staff from wearing gloves. She further indicated staff were not to touch the food with their gloved hands after they have been touching other items. She further indicated staff were to wear gloves if they were touching food but could not touch anything else. She indicated the fried eggs should have been heated up to obtain the temperature of 140 degrees before being served.</p> <p>Review of the current 2011 Dietary Hand washing policy provided by the Dietary Food Manager indicated dining service employees must effectively clean hands at appropriate kitchen hand sinks with proper cleaning compounds prior to handling, preparing, serving, and distributing food, working with clean utensils, dishes and equipment.</p> <p>Review of the current 2011 Dietary</p>						

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	<p>Disposable Glove policy provided by the Dietary Food Manager indicated wearing disposable gloves is not a substitution for appropriate effective, thorough and frequent hand washing. Dining service employees should wash their hands before putting on gloves. Dining service employees should change gloves after touching items, equipment, utensils, trash can lids or soiled work areas.</p> <p>3. On 9/19/14 at 9:15 a.m., during the Full Kitchen Sanitation Tour the following was observed:</p> <p>A. The screens above the stove were dusty and dirty with dust balls hanging from down.</p> <p>B. There were food crumbs on the shelf below the steam table. There was a heavy accumulation food crumbs and grease by the table legs of the steam table. The silver accordion window by the steam table was dirty.</p> <p>C. The bottom of the convection oven had a black dried substance inside the oven.</p> <p>D. There was a heavy accumulation of food crumbs and debris along with food spillage on the wall by the base board under the food prep table. There was a</p>			

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F000431 SS=E	<p>large amount of food crumbs and debris under both food prep tables.</p> <p>E. There was heavy accumulation of food crumbs along the baseboard and under the metal racks in the dry food storage room.</p> <p>Interview with the Dietary Food Manager on 9/19/14 at 9:45 a.m., indicated all of the above was in need of cleaning and/or repair.</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under</p>						

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	<p>proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure multi-dose insulin vials were dated when opened on 4 of 4 wings throughout the facility. This had the potential to affect the 46 insulin dependent diabetic residents who resided in the facility. (B, C, D and ACU wing. Residents #47, 89, #160, and #252)</p> <p>Findings include:</p> <p>1. Observation of the Medication cart on the C Wing on 9/22/14 at 8:55 a.m., indicated the following:</p> <p>a. A vial of Lantus insulin for Resident #252 was delivered to the facility on 9/14/14. The insulin vial was not dated when opened.</p> <p>b. A vial of Lantus insulin for Resident #89 was delivered to the facility on</p>	F000431	<p>F431 med storage The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Insulin for res 47, 89, 160 and 252 were destroyed 9-22-14 and new insulin ordered. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: Any resident that has insulin ordered has the potential to be affected by the alleged deficient practice. All Insulin audited for date of opening on 9-22-14. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Nurses to be educated on 10-15, 16, 17, 2014 on Medication Storage (exhibit S) Audit created How the corrective action will be monitored to ensure the</p>	10/22/2014

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	<p>9/20/14. The insulin vial was not dated when opened.</p> <p>Interview with LPN #4 at the time, indicated the insulin vials should have been dated when opened.</p> <p>2. Observation of the Medication cart on the D Wing on 9/22/14 at 10:02 a.m., indicated the following:</p> <p>a. A vial of Levimir insulin was opened and observed in the manufacturers box. There was no label on the box or insulin vial and there was no date to indicate when the vial was opened.</p> <p>3. Observation of the Medication cart on the ACU Wing on 9/22/14 at 10:05 a.m., indicated the following:</p> <p>a. A vial of Humulin Regular insulin for Resident #160 was delivered to the facility on 9/18/14. The insulin vial was not dated when opened.</p> <p>4. Observation of the Medication Cart on the B Wing on 9/22/14 at 10:09 a.m., indicated the following:</p> <p>a. A vial of Novolin Regular insulin for Resident #47 was delivered to the facility on 9/11/14. The insulin vial was not dated when opened.</p>		<p>deficient practice does not recur: Audit created (Exhibit T): Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		

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F000441 SS=E	<p>Interview with the Assistant Director of Nursing (ADON) on 9/22/14 at 10:30 a.m., indicated the insulin vials should have been dated when opened.</p> <p>Review of the facility policy titled "Specific Medication Administration Procedures, Injectable Medication Administration" on 9/22/14 at 11:25 a.m., which was provided by the ADON and identified as current, indicated the following: "Write date opened and expiration date on container if new vial used. Refer to table of shortened expiration dates for expiration date to use."</p> <p>3.1-25(j)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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</p>			

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	<p>resident; and</p> <p>(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, record review and interview, the facility failed to ensure hand washing was completed after direct resident contact and before and after glove use for 3 of 8 residents observed during medication administration. The facility also failed to ensure 2 residents had contact isolation precautions implemented. (Residents #B, #C, #G, #H, and #J)</p> <p>Findings include:</p> <p>1. On 9/18/14 at 11:03 a.m., RN #2 was observed completing a glucometer (a test</p>	F000441	F 441 Isolation/Infection Control/Prevent spread The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for resident G. 9-18-14 nurse for resident G was educated to wash hands when gloves are removed and prior to applying new gloves. Unable to correct the alleged deficient practice for resident H. Nurse for resident H was educated to wash hands before administering nebulizer treatment/assessment and before exiting a residents room. Unable to correct the	10/22/2014	

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	<p>to check blood sugar) for Resident #G. The RN completed the resident's glucometer and left the room. The RN removed her gloves, wiped the glucometer with a germicidal wipe, drew up the resident's insulin and then put on a new pair of gloves. The RN did not wash her hands nor use an alcohol based hand gel when the old gloves were removed and prior to applying the new gloves.</p> <p>2. On 9/19/14 at 8:30 a.m., LPN #5 assessed Resident #H's breath sounds and checked his oxygen saturation. The LPN then prepared the resident's nebulizer treatment and applied the resident's face mask. After the completion of the nebulizer treatment, the resident's breath sounds and oxygen saturation was again assessed. The LPN did not wash her hands nor use an alcohol based hand gel prior to leaving the resident's room. At the completion of the resident's nebulizer treatment, the LPN proceeded immediately to Resident #J's room at 8:51 a.m. The LPN was going to complete the resident's glucometer. The LPN put on a pair of gloves. She did not wash her hands nor did she use an alcohol based hand gel prior to putting on the gloves.</p> <p>Interview with the LPN on 9/19/14 at 9:00 a.m., indicated that she should have</p>		<p>alleged deficient practice for resident B. Isolation carts/sign set up for resident B on 9-19-14 Unable to correct the alleged deficient practice for resident C. Discontinued isolation for resident C. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken: All residents have the potential to be affected by the alleged deficient practice. Audit completed on residents in isolation. Signage/bins added if needed on 9-20-14. Audit completed 9-22-14 and on going for staff for hand washing/hand hygiene. Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Nurses to be inserviced on 10-15, 16, 17 2014 on "Hand Washig/Hand Hygeine" and "Isolation." (Exhibit U and V)Audit CreatedHow the corrective action will be monitored to ensure the deficient practice does not recur: Audit created (Exhibit W): Audit to be completed by nursing supervisor/unit manager weekly x 8 weeks, twice a month x 2 months, monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>	

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	<p>washed her hands or used hand gel after giving Resident #H his neb treatment and prior to putting on the clean gloves.</p> <p>Review of the facility policy titled "Hand washing/Hand Hygiene" on 9/19/14 at 3:30 p.m., which was provided by the Assistant Director of Nursing (ADON) and identified as current, indicated the following:</p> <p>- "Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)."</p> <p>- "In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: after contact with a resident's intact skin and after removing gloves."</p> <p>3. Review of Resident #B's record on 9/17/14 at 9:00 a.m., indicated the Physician ordered contact isolation related to Clostridium difficile (C. diff), an infectious diarrhea, for the resident on 8/27/14. There was no order for the isolation to be discontinued.</p>			

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	<p>On 9/17/14 at 9:30 a.m. the rooms for Residents #B and #C were observed with LPN #1. There were no isolation carts in the rooms or outside the rooms and there was no sign on the doors to indicate the residents were on contact isolation precautions. The LPN indicated at that time there should be isolation carts and signage on the doors.</p> <p>4. Review of Resident #C's record on 9/17/14 at 9:10 a.m., indicated the Physician ordered contact isolation due to Vancomycin-resistant Enterococci (VRE) in her urine for the resident on 8/25/14. There was no order for the isolation to be discontinued.</p> <p>Interview with CNA #1 on 9/17/14 at 9:28 a.m. in the B Wing middle hall, indicated there were no residents on that hall that were on isolation precautions.</p> <p>Interview with LPN #1 on 9/17/14 at 9:29 a.m., indicated two residents in that hall were on contact isolation precautions. Resident #B had C. diff., and Resident #C had VRE in her urine.</p> <p>On 9/17/14 at 9:30 a.m. the rooms for Residents #B and #C were observed with LPN #1. There were no isolation carts in the rooms or outside the rooms and there</p>			

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	<p>was no sign on the doors to indicate the residents were on contact isolation precautions. The LPN indicated at that time there should be isolation carts and signage on the doors.</p> <p>Interview with the B Wing Unit Manager on 9/17/14 at 9:35 a.m. indicated there should be isolation carts in the rooms and signs on the doors of residents who are on isolation precautions and staff should be aware of which residents were on isolation precautions.</p> <p>The current policy Multidrug-Resistant Organisms, dated August 2012, was received from RN #3 on 9/17/14 at 11:35 a.m. The policy indicated, "15. Contact Precautions shall not be discontinued until the Infection Preventionist /designee reviews the situation and the Attending Physician approves the discontinuation".</p> <p>Interview with the Assistant Director of Nursing on 9/19/14 at 1:20 p.m., indicated they did not have a policy for isolation precautions. She indicated a Physician had to order isolation precautions to be initiated and discontinued. She indicated when a resident was determined to need isolation precautions, a sign should be placed on the door, an isolation cart should be outside the room, a bin for contaminated</p>			

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F000465 SS=E	<p>materials should be inside the room and the staff care cards should be updated. After isolation precautions were completed the room should be thoroughly cleaned by housekeeping.</p> <p>This Federal tag relates to Complaint IN00155592.</p> <p>3.1-18(b)(2) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred walls, peeling paint, missing pull cords, holes in the walls, broken bed bumpers, and missing baseboards for 4 of 4 units. The facility also failed to ensure the kitchen was clean related to dirty and dusty ceiling vents, food crumbs along the baseboard in under the dish machine, paper products and debris on the freezer floor, dirty PVC pipes, dirty floor tile and dirty metal pipes. (The B, C, D, and E units and the Main Kitchen)</p>	F000465	<p>F 465 Sanitary/Environment The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Ceiling vent in the ice machine area was cleaned 9-16-14. Ceiling light changed 9-20-14, ceiling above the convection over cleaned on 9-22-14, B 119 - repaired, B122 repaired, B125 , D331 (335) complete, E313 completed, floor cleaned of black substance by food prep table and sink, paper products removed from the floor in the freezer, floor cleaned under the 3 compartment sink and dish machine along the baseboard, back splash cleaned, dust</p>	10/22/2014	

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	<p>Findings include:</p> <p>1. During the Brief Kitchen Sanitation tour on 9/15/14 at 9:10 a.m., the following was observed:</p> <p>A. There were Styrofoam cups and paper products noted on the floor in the freezer.</p> <p>B. The ceiling vent in the ice machine area had a heavy accumulation of black dirt and dust.</p> <p>C. There was a heavy accumulation of dirt and debris under three compartment sink and dish machine along the baseboard. There was missing baseboard in the corner of the wall by the window under the dish machine. There were three forks noted on the floor in and area where the baseboard was missing. There was a large amount of spackle noted on floor by the baseboard in corner under the three compartment sink.</p> <p>D. The entire back splash under the dish machine was dirty with dried food spillage.</p> <p>2. On 9/19/14 at 9:15 a.m., during the Full Kitchen Sanitation Tour the following was observed:</p> <p>A. A ceiling light located over the food</p>		<p>cleaned under the hand washing sink. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken : all residents have the ability to be affected by the alleged deficient practice. Environment audited and cleaned. Repairs to be on going.</p> <p>Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Staff to be in-serviced on entering environmental concerns in Care Track under Work Orders. Audit created How the corrective action will be monitored to ensure the deficient practice does not recur Audit created (Exhibit #465): Audit to be completed by Maintenance Director/designee weekly x 8 weeks, twice a month x 2 months, monthly x 4 months.</p> <p>Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-1</p>	

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	<p>prep table was burned out.</p> <p>B. The ceiling above the convection oven was rusty and had peeling paint noted.</p> <p>C. There was a heavy accumulation of dust on the metal pipes and on the white PVC piped under the hand washing sink by the steam table.</p> <p>D. there was a heavy accumulation of a thick black substance on the floor by both food prep tables and by the food prep sink. The metal pipes were dirty and the drain covers were black and discolored.</p> <p>Interview with the Dietary Food Manager on 9/19/14 at 9:45 a.m., indicated all of the above was in need of cleaning and/or repair.</p> <p>3. During the Environmental Tour on 9/19/14 at 11:00 a.m., with the Maintenance and Housekeeping Supervisors, the following was observed on the B Unit:</p> <p>A. In Room B112, a large area of paint on the bathroom wall was peeling. The floor mat next to bed #1 was stained and dirty. Two residents resided in this room.</p> <p>B. In Room B119, there was a hole in the wall near the floor in the bathroom. Two</p>				

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	<p>residents shared this bathroom.</p> <p>C. In Room B122, the closet door was gouged and had a small hole in it. The chair railing where bed #1 used to be was marred and chipped. One resident resided in this room.</p> <p>D. In Room B125, the bed bumper behind bed #1 was broken off and propped against the wall. Two residents resided in this room.</p> <p>During the Environmental tour on 9/19/14 at 11:08 a.m. with the Maintenance and Housekeeping Supervisors the following was observed on the C Unit:</p> <p>A. In Room C201, the bathroom doorframe and baseboard were chipped and marred. Two residents shared this bathroom.</p> <p>B. In Room C204, the bed bumper was missing behind bed #1, and the wall was marred. The heating register was chipped. Two residents resided in this room.</p> <p>C. In Room C212, the bathroom walls were marred and the paint was peeling behind the toilet. The call light fixture was loose from the wall and the cable</p>			

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	<p>outlet was missing screw. Two residents resided in this room.</p> <p>D. In Room C213, there was an area of peeling paint outside the bathroom wall, the walls were marred in the bathroom and the heat register was chipped. The bed bumper behind bed #1 was broken off. Two residents resided in this room.</p> <p>E. In Room C223, the wall behind bed #1 was damaged and missing drywall, the non-slip strips on the floor were peeling off. There was a missing section of baseboard next to the closet. There was no pull cord on the bathroom call light. Two residents resided in this room.</p> <p>F. In Room C226, there was no pull cord for the bathroom call light and the bathroom walls were marred. Two residents shared this bathroom.</p> <p>G. In Room C231, the wall under the toilet was damaged with stains and a hole, and the bathroom walls were marred. Two residents shared this bathroom.</p> <p>During the Environmental Tour on 9/19/14 at 11:20 a.m., with the Maintenance and Housekeeping Supervisors, the following was observed on the D Unit:</p>				

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F000520 SS=E	<p>A. In Room D331, there was an area of unpainted, white plaster on the bathroom wall. An outlet in the room was missing the faceplate. Two residents resided in this room.</p> <p>During the Environmental Tour on 9/19/14 at 11:25 a.m., with the Maintenance and Housekeeping Supervisors, the following was observed on the E Unit:</p> <p>A. In Room E313, the grab bars above the toilet were loose and the non slip strips were peeling off. On the initial tour on 9/16/14 at 10:00 a.m., there was a puddle of water under the toilet. The Maintenance Supervisor indicated he had repaired that on 9/17/14. Three residents shared this bathroom.</p> <p>The Maintenance and Housekeeping Supervisors indicated the above items were in need of repair.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services;</p>			

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	<p>a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify the non-compliance of infection control related to isolation precautions through the facility's quality assurance protocol. (Residents #B and #C)</p> <p>Interview with the Assistant Director of Nursing (ADON) on 9/19/14 at 1:10 p.m., indicated the Quality Assessment and Assurance (QA & A) committee consisted of herself, the Director of Nursing (DON), Administrator, Medical Director and department heads. She indicated the committee met monthly. She indicated the committee discussed infection control concerns at each QA & A meeting.</p>	F000520	F 520 QA The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Infection control Program currently in QAPI (QAA) but not specifically for isolation. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken : All residents in Residents in isolation have the potential to be affected by the alleged deficient practice. Audit completed on residents in isolation. Signage/bins added if needed on 9-20-14. Measures that were put in place or what systemic change to ensure that the deficient practice does not	10/22/2014

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	<p>Further interview with the ADON and DON on 9/22/14 at 10:30 a.m., indicated the QA & A committee was not aware of a concern related to following isolation precautions as part of the infection control program.</p> <p>The Plan of Correction to a prior survey dated 8/13/13, indicated audits to ensure isolation precautions were being followed were to be completed five times a week for 30 days; then two times a week for 60 days; then weekly for 90 days. The DON indicated there were no audits available for review after 11/8/13.</p> <p>Review of Resident #B's record on 9/17/14 at 9:00 a.m., indicated the Physician ordered contact isolation related to Clostridium difficile (C. diff), an infectious diarrhea, for the resident on 8/27/14. There was no order for the isolation to be discontinued.</p> <p>Review of Resident #C's record on 9/17/14 at 9:10 a.m., indicated the Physician ordered contact isolation due to Vancomycin-resistant Enterococci (VRE) in her urine for the resident on 8/25/14. There was no order for the isolation to be discontinued.</p> <p>Interview with CNA #1 on 9/17/14 at</p>		<p>recur: Nurses to be in-serviced on 10-15, 16, 17 2014 on "Hand Washing/Hand Hygiene." Department Heads and Managers to be inserviced on "QAPI - 5 Steps for Success." (exhibit Y and U) How the corrective action will be monitored to ensure the deficient practice does not recur: Audit created (Exhibit # Z): Audit to be completed by Executive Director/designee monthly x 8 months or until compliance is achieved.</p> <p>Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>				

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	<p>9:28 a.m. in the B Wing middle hall, indicated there were no residents on that hall that were on isolation precautions.</p> <p>Interview with LPN #1 on 9/17/14 at 9:29 a.m., indicated two residents in that hall were on contact isolation precautions. Resident #B had C. diff., and Resident #C had VRE in her urine.</p> <p>On 9/17/14 at 9:30 a.m. the rooms for Residents #B and #C were observed with LPN #1. There were no isolation carts in the rooms or outside the rooms and there was no sign on the doors to indicate the residents were on contact isolation precautions. The LPN indicated at that time there should be isolation carts and signage on the doors.</p> <p>Interview with the B Wing Unit Manager on 9/17/14 at 9:35 a.m. indicated there should be isolation carts in the rooms and signs on the doors of residents who are on isolation precautions and staff should be aware of which residents were on isolation precautions.</p> <p>The current policy Multidrug-Resistant Organisms, dated August 2012, was received from RN #3 on 9/17/14 at 11:35 a.m. The policy indicated, "15. Contact Precautions shall not be discontinued until the Infection Preventionist /designee</p>			

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F009999	<p>reviews the situation and the Attending Physician approves the discontinuation".</p> <p>Interview with the Assistant Director of Nursing on 9/19/14 at 1:20 p.m., indicated they did not have a policy for isolation precautions. She indicated a Physician had to order isolation precautions to be initiated and discontinued. She indicated when a resident was determined to need isolation precautions, a sign should be placed on the door, an isolation cart should be outside the room, a bin for contaminated materials should be inside the room and the staff care cards should be updated. After isolation precautions were completed the room should be thoroughly cleaned by housekeeping.</p> <p>This Federal tag relates to Complaint IN00155592.</p> <p>3.1-52(b)(2)</p> <p>3.1-14 PERSONNEL</p>	F009999	F 9999 QA The corrective action(s) that were	10/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368			
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	<p>(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by :</p> <p>Based on record review and interview, the facility failed to ensure the required annual dementia training was completed for 3 of 5 employee records reviewed for dementia training. (CNA #2, CNA #3 and CNA#4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of CNA #2's personnel record on 9/22/14 at 9:30 a.m., indicated the employee was hired on 11/19/09. There was no dementia training certificate for the previous year in the CNA's record. 2. Review of CNA #3's personnel record 		<p>accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken : All residents have the potential to be affected by the alleged deficient practice. CNA 2, 3, and 4 were informed of the need for 3 hours of dementia training on 9-23-14 Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Audit completed on all staff. Staff that need 3 hours of dementia training notified 9-23-13 How the corrective action will be monitored to ensure the deficient practice does not recur: Nurse educator or deisgnee will monitor staffing monthly for needed yearly dementia hours. Staff will be given sufficient notice that they need dementia inservice hours. How the corrective action will be monitored to ensure the deficient practice does not recur: How the corrective action will be monitored to ensure the deficient practice does not recur: Audit created (Exhibit ZZ): Audit to be completed weekly x 8 weeks, twice a month x 2 months,</p>				

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	<p>on 9/22/14 at 9:35 a.m., indicated the employee was hired on 1/31/12. There was no dementia training certificate for the previous year in the CNA's record.</p> <p>3. Review of CNA #4's personnel record on 9/22/14 at 9:40 a.m., indicated the employee was hired on 7/3/01. There was no dementia training certificate for the previous year in the CNA's record.</p> <p>Interview with the Staff Development Coordinator on 9/22/14 at 10:35 a.m., indicated there was no annual dementia training provided to the CNA's.</p>		<p>monthly x 4 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 10-22-14.</p>		