

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  07/16/2015
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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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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00176471, IN00177742, IN00177395, and IN00177997</p> <p>Complaint IN00176471- Substantiated. Federal/State deficiencies related to the allegations are cited at F166, F309, F441, and F465.</p> <p>Complaint IN00177742- Substantiated. Federal/State deficiency related to the allegations is cited at F441 and F 502.</p> <p>Complaint IN00177395- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F225, F226, F314 and F502.</p> <p>Complaint IN00177997- Substantiated. Federal/State deficiencies related to the allegation are cited at F157 and F314.</p> <p>Survey dates: July 13, 14, 15 &amp; 16, 2015</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Census bed type: SNF/NF: 164</p>	F 0000	<p>Submission of this Response and Plan of Corrections is nota legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a plan of correction with ten (10) days of the survey as a condition of participation in the Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. This facility is asking for a desk review for this survey.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F 0157 SS=D Bldg. 00	<p>Total: 164</p> <p>Census payor type: Medicare: 25 Medicaid: 121 Other: 18 Total: 164</p> <p>Sample: 14</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</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 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>			

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	<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 observation, record review, and interview, the facility failed to ensure the Physician was notified of the need to change the resident's treatment related to the development of pressure ulcers for 2 of 3 residents reviewed for a change in condition in a sample of 14. (Residents #E and #F)</p> <p>Findings include:</p> <p>1. On 7/13/15 at 1:15 p.m., Resident #F was observed in bed. CNA's #1 and #2 were providing incontinence care for the resident. An open area was observed on the resident's right upper inner thigh area. The area measured approximately 2.5 x 2.5 cm (centimeters). The center of the open area was red. The Unit Supervisor was present at this time.</p> <p>The record for Resident #F was reviewed on 7/13/15 at 1:00 p.m. There resident's</p>	F 0157	<p>It is the intent of this facility to ensure that Physicians are notified of the need to change the resident's treatment related to development of pressure ulcers.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p>No residents were identified as this was a complaint survey.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All resident's have the potential of being affected by this alleged deficient practice. A skin sweep was completed throughout the facility on 7/10/15. Physician was notified on any new areas, treatment and family</p>	08/15/2015

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	<p>diagnoses included, but were not limited to, diabetes mellitus. The current Physician orders were reviewed. There were no Physician orders for any treatments to the open area noted. The Nursing Progress Notes were reviewed. There was no documentation of Physician notification the ulcer prior to the above observation.</p> <p>A Wound Evaluation Flow Sheet was initiated on 7/13/15. The sheet indicated a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough) pressure ulcer was noted to the resident's right inner thigh. The area measured 2 cm x 2 cm.</p> <p>When interviewed on 7/13 at 1:30 p.m., CNA #1 indicated the resident had a history of open areas. The CNA indicated she changed the resident earlier in the morning after breakfast and first noted the open area at that time. The CNA indicated she did not inform the Nurse of the new open area at that time.</p> <p>When interviewed on 7/13/15 at 1:45 p.m., the Unit Supervisor indicated the area noted on the resident's upper thigh was a pressure ulcer and a new Wound Evaluation form was being completed. The Unit Supervisor also indicated a new</p>		<p>notification was also verified. A second skin sweep was completed on 7/17/15 with no new issues identified. Facility audited the SBAR for resident's identified as having pressure ulcers to assure Physician notification was completed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>Nursing staff were in-serviced on completion of a SBAR and the importance of Physician notification relating to a change of condition. The facility has added to its systems that the DNS/designee will review weekly skin assessments to assure an SBAR is completed as needed and SBAR's will be reviewed at Clinical Review meetings to assure that the Physician has been notified.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>Results of the SBAR audits will be presented to the QAA with noted trends. The QAA will make recommendations to the Action Plan as needed. QAA will monitor monthly for 6 months and quarterly for 2 quarters .</p> <p><b>Date systemic changes will be</b></p>		

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	<p>order had been obtained to apply Calazine ointment to the area every shift.</p> <p>2. The closed record for Resident #E was reviewed on 7/13/15 at 3:20 p.m. The resident's diagnosis included, but were not limited to, diabetes mellitus, dementia, high blood pressure, chronic pain, and foot fracture.</p> <p>A Wound Evaluation Flow Sheet initiated on 4/18/15 indicated an ulcer to the right outer ankle was observed. The pressure ulcer was noted to be a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough) ulcer. The pressure ulcer measured 2.5 cm x 1 cm with no exudate. The wound margins were uneven and the surrounding tissue was intact.</p> <p>A Physician's order dated 4/21/15 at 3:26 a.m. was reviewed. The order was to cleanse the Stage II wound to the right outer ankle with normal saline, apply Silvadene 1% Cream, and cover the ulcer with a dry dressing daily and prn (as needed) for soilage or detachment.</p> <p>When interviewed on 7/16/15 at 2:50 p.m., the Unit Manager indicated the right ankle pressure ulcer was first observed on 4/18/15 and the Physician</p>		completed: 8/15/2015	

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F 0166 SS=D Bldg. 00	<p>should have been notified at the time the ulcer was first observed to obtain orders to treat the ulcer.</p> <p>The facility policy titled "Prevention of Pressure Ulcer" was reviewed on 7/15/15 at 10:05 a.m. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated notification of the Physician was required when a new pressure ulcer was identified.</p> <p>This Federal tag relates to Complaints IN00177395 and IN00177997.</p> <p>3.1-5)(a)(3)</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES 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. Based on observation, record review, and interview the facility failed to ensure resident and family grievances were thoroughly investigated related to residents not receiving medications as ordered. (Resident #C) The facility also failed to ensure grievances voiced during Resident</p>	F 0166	<p>It is the intent of this facility to ensure resident and family grievances are thoroughly investigated and that grievances voiced during Resident Council Meetings are addressed and reported back to the Resident Council.</p>	08/15/2015			

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	<p>Council Meetings were addressed and resolutions were reported back to the Resident Council.</p> <p>Findings include:</p> <p>1. The Resident Council Minutes from the 5/11/15 meeting were reviewed. New Business noted at his meeting included a concern about Nurses and CNA's listening to headphones and not listening to residents.</p> <p>The Resident Council Minutes from the 6/3/15 meeting were reviewed. The concern voiced at the 5/11/15 was not included with the review of "Old Business." New concerns were voiced at this meeting again regarding aides using phones to listen to music.</p> <p>When interviewed on 7/15/15 at 1:33 p.m., the Activity Director indicated the residents had voiced concerns related to the use headphones and staff not listening to the resident at the 5/11/15 meeting. The Director indicated the concerns were voiced again at the 6/3/15 meeting and the concerns were not addressed at his time. The Activity Director indicated when new concerns were voiced at a meeting a Grievance form was to be completed and given to the appropriate department to address the grievance. The</p>		<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p>No residents were identified as this was a complaint survey.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All resident's have the potential to be affected by this alleged deficient practice. A review of grievance forms dated in the past 30 days was completed to assure a satisfactory resolution was documented. Staff was in-serviced on the guidelines of initiating a grievance form and submitting to management. Facility Management team was also in-serviced on the guidelines for responding to a grievance form involving their department. The Activity department was in-serviced on the guidelines of processing and tracking concerns voiced by the Resident Council.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The Resident Council President was educated on Council Meeting procedures including the initiation of concerns from Council Meetings. Concern forms are reviewed during Management Team meetings. Open concerns will be reviewed by team through completion. The Executive</p>	
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	<p>Activity Director indicated this had not been done after the 5/11/15 or after the 6/3/15 concerns were voiced by the resident about the staff using headphones. The Director indicated a meeting was to be held today.</p> <p>When interviewed on 7/16/15 at 8:30 a.m., the Resident Council President indicated the above concerns were brought up at both of the meeting and had not been addressed.</p> <p>2. A Grievance Form dated 6/22/15 was reviewed. The Grievance was "heard by" the "Hot line." The concerns section noted there were medication and treatment concerns voiced by Resident #C's family on an attachment. The attachment letter was dated 5/22/15. Another attachment letter was dated 5/23/15. This attachment letter included concerns about the resident's medications also. One of listed concerns referred to the resident's Clonidine patch (a medication to treat high blood pressure. The concern indicated the patch was to be applied weekly and had not been applied on Thursday.</p> <p>The "Nature of resolution" section on the form indicated an investigation was on file and all concerns addressed per the</p>		<p>Director/designee will review and sign resolved concerns. Resident Council President will review concern resolutions to assure timely response.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>Resident Council concerns will be reviewed at the following Resident Council Meeting. Any unresolved concerns will be resubmitted as a continued concern. A list of continued concerns will be submitted to the QAA for recommendations. QAA will monitor for trends and tracking, monthly for 6 months and quarterly for 2 quarters.</p> <p><b>Date systemic changes will be completed: 8/15/2015</b></p>				

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	<p>care conference.</p> <p>The record for Resident #C was reviewed on 7/14/15 at 9:28 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, diabetes mellitus, gastrostomy, and cerebrovascular disease.</p> <p>The 5/2015 Medication Administration record was reviewed. There was a Physician's order for a Clonidine 0.3 mg/her patch to be applied every Thursday. The patch had not been signed out as applied on Thursday 5/21/15.</p> <p>When interviewed on 7/14/15 at 10:00 a.m. the Director of Nursing indicated the facility addressed the concerns. The Director of Nursing confirmed the Clonidine patch had not been signed out on 5/21/15 as the grievance had listed. The Director of Nursing indicate she did not assess the resident at the time of the grievance to observe if the patch was in place or not.</p> <p>The facility "Grievance Guideline" policy was reviewed on 7/15/15 at 2:40 p.m. The facility Administrator indicated the policy was current. The policy indicated Grievance Forms were to be completed when grievances were noted during Resident Council. The policy also indicated the investigations of grievances</p>			

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F 0225 SS=D Bldg. 00	<p>were to include evaluations of all aspects of the situation. The policy also indicated investigation and resolution of grievances were to be completed within five working days of the grievance.</p> <p>This Federal tag relates to Complaint IN00176471.</p> <p>3.1-7(a)(2)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all</p>			

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	<p>alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an injury of unknown origin for a dependent resident was thoroughly investigated related to not completing interviews with all staff who were present in the facility. The facility also failed to ensure a staff member provided accurate information related to reporting which staff member was the first to observe the resident with an injury off unknown origin and failed to interview ancillary staff after the hospital Physician voiced concerns about the resident's linens for 1 of 3 Abuse investigations reviewed. (Resident #E) (LPN #3)</p> <p>Finding includes:</p> <p>The closed record for Resident #E was reviewed on 7/13/15 at 3:20 p.m. The resident's diagnosis included, but were not limited to, diabetes mellitus,</p>	F 0225	<p>It is the intent of this facility to ensure an injury of unknown origin for a dependent resident is thoroughly investigated. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b> No residents were identified as this was a complaint survey. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential of being affected by this alleged deficient practice. Staff was in-serviced on the guidelines and importance of reporting any suspected or alleged abuse/neglect, including injury of unknown origin for a dependent resident. The Facility Management team was in-serviced on facility policy involving investigations. While</p>	08/15/2015			

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	<p>dementia, high blood pressure, chronic pain, and foot fracture.</p> <p>The 7/2015 Physician orders were reviewed. An order was written on 7/4/15 to send the resident to the hospital Emergency Room for an evaluation and treatment.</p> <p>The 4/15/15 Minimum Data Set (MDS) admission assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident required extensive assistance of one staff member for bed mobility, personal hygiene, and dressing. The assessment also indicated the resident required extensive assistance of two staff members for transfers and had impairment in range of motion on both sides of her upper and her lower extremities.</p> <p>The 7/3/15 Nursing Progress Notes were reviewed. The last entry made on 7/3/15 was at 10:21 a.m. This entry indicated the resident was in bed with her eyes closed and was aroused without difficulty to verbal stimuli. The entry also indicated no acute distress was evident at this time.</p>		<p>the facility cannot control what information is reported by staff during interviews, staff were in-serviced on the importance of immediately reporting as many facts as they can accurately recall, and to report any additional facts that they may not have recalled during the initial interview as timely as possible. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> While this facility followed best practices in this investigation of notifying State Agencies, local police department, Corporate Compliance and utilizing outside legal service and local detectives in the interview process; this facility re-educated staff on the importance of reporting any forms of abuse/neglect and gathering and documenting of information relating to an event. Facility compliance officer/designee will oversee investigations for injuries of unknown origin to assure these investigations are complete and corporate oversight is initiated if needed. Data Quality Improvement (DQI) will be reviewed in Clinical review meetings to verify investigation is thorough and complete. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> Open investigations will be</p>				

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	<p>The 7/4/15 Nursing Progress Notes were reviewed. The first entry was entered at 8:30 a.m. This entry was a SBAR-Change of Condition note. The note indicated the LPN entered the residents room to administer morning medications and noted an open area to the resident's left forehead with no frank bleeding noted. A large amount of dried sanguineous (red drainage usually from trauma of a blood vessel) drainage was noted around the area and in the resident's hair and on her hands. The area measured 3.1 cm (centimeters) x 1.0 cm x 0.2 cm. Light bruising was noted to the resident's left temple measuring 5.5 cm x 5.0 cm with no swelling noted. The writer had passed by and looked into the room several times prior and the area and the drainage were not visible from the doorway. The resident was alert and talking in her usual manner and when asked what happened responded "Oh I love you, I love you, I'm sorry, I'm sorry." The entry also noted the resident was bed/chair ridden and had bilateral leg immobilizers. The areas were cleansed with normal saline and covered with a foam dressing. An entry made at 9:30 a.m., indicated the ambulance arrived and the resident was transported to the hospital.</p>		<p>reviewed in QAA for recommendations. QAA will monitor monthly for 90 days or until 100% compliance is obtained. <b>Date systemic changes will be completed: 8/15/2015</b></p>	

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	<p>A facility report of the 7/4/15 incident was reviewed. The report indicated on 7/4/15 the Nurse entered the resident's room to administer medications. The resident was in bed and an open area was noted to the resident's left forehead area with bruising noted to the left temple area also. The laceration measured 3.1 cm x 1.0 cm x 0.2 cm. The bruise measures 5.5 cm x 5.0 cm . A large amount of dried blood was noted around the open area.</p> <p>The resident's Hospital Records were reviewed on 7/14/15. The 7/4/15 Emergency Room Physician note indicted the resident was brought in from a nursing home with a reported laceration to the forehead of unknown origin. The resident had severe dementia and was bed bound with bilateral lower extremity fractures. The Physician's physical exam noted the resident had a large hematoma to the left forehead with "central gaping". The laceration was approximately 3 cm x 1 cm. A CT scan (test that shows the brain) of the head was completed on 7/4/15 with no intracranial hemorrhages noted and the injury apparently occurred overnight. At this time there was no known cause, the laceration was repaired with (4) sutures, APS (Adult Protective Services) were called, and case manager in ER was in to see the patient.</p>			

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	<p>The Emergency Room Nursing Notes were reviewed An entry made on 7/41/5 at 11:04 a.m. indicated the resident presented by EMS (Emergency Medical Service) who were called to the Nursing Home in Portage related to resident with a head injury and EMS had been advised by the Nursing Home staff the resident was found lying in bed with dried blood on her face and hands. An entry made on 7/4/15 at 1:22 p.m. indicated a report of Abuse was to filed.</p> <p>A 7/4/15 hospital Consult note indicated the hospital spoke with the patient's Nurse at the Nursing Home to discuss the case and the Nurse indicated the resident was found with a large gash to her head with dried blood and the resident was cleaned up immediately. The Nurse also indicated she suspected the event occurred overnight before shift change.</p> <p>A 7/6/15 hospital History and Physical indicated the resident had been found in bed with a head injury and dried blood on her face and hands. The noted also indicted there was an investigation for possible abuse.</p> <p>The report of the investigation of the injury for Resident #E was reviewed. The report indicated the Administrator</p>			

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	<p>was informed of the injury of unknown origin on 7/4/15. The initial report indicated the resident had a laceration to the left upper forehead and no bruising or other indication of injury were noted. The report indicated officers from the Police Department met with the facility Administrator and they went to the resident's room. The report indicated the Police returned to the facility on 7/10/15 and indicated they were continuing the investigation as a criminal investigation as there was an open question as to who removed the soiled linens from the bed.</p> <p>The facility Administrator and the DON (Director of Nursing) were interviewed on 7/14/15 beginning at 6:55 a.m. The DON indicated she was notified on 7/4/15 and it was reported the Day shift Nurse was the first person to see the resident and called for help. The resident was sent to the Emergency Room. The Unit Manager conducted staff interviews on 7/4/15. The DON indicated the night shift CNA was suspended on 7/4/15 as she was the last one noted to have provided care for the resident. The DON indicated the night CNA's interview indicated she last provided incontinence care to the resident by herself at approximately 5:45 a.m. The CNA was noted to have clocked out at 6:38 a.m. on 7/4/15.</p>			

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	<p>The facility Administrator indicated Laundry Aide #1 was interviewed on 7/6/15 as she was reported to have picked up laundry bins on the resident's unit at 6:30 a.m. on 7/4/15 and reported noting bloody linens on the unit.</p> <p>The DON indicated a Housekeeping staff member was interviewed on 7/6/15 and reported having seen spots of blood on the residents room floor, on the chair, and on the floor between bed and the bathroom and on the resident.</p> <p>The Unit Manager was interviewed on 7/14/15 at 10:15 a.m. The Unit Manager indicated on 7/4/15 the day shift Nurse called her and informed her she had found the resident at 8:29 a.m. with blood on her face and her hands. The Unit Manager indicated the next day she found out that the Nurse had been called into the room by the Housekeeper who had reported she saw the resident in her room with blood on her. The Unit Manager indicated if she had been notified the Housekeeper was the first to see the resident the Housekeeper could have been interviewed on 7/4/15.</p> <p>The facility Administrator, DON and Unit Manager were interviewed on 7/15/15 at 11:15 a.m., the Unit Manger</p>			

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	<p>indicated she had been mistaken related to the day the day Nurse reported to her that it was the housekeeper who first observed the resident on 7/4/15. The Unit Manager indicated this information was reported to her first on 7/6/15 and not 7/5/15 as per the previous interview. The Unit Manager indicated she had not spoken to the Housekeeper on Monday (7/6/15).</p> <p>When interviewed on 7/16/15 at 10:20 a.m. the Alzheimer Unit Director indicated she was the Unit Manager on Duty on the 4th. The Manager indicated she was answering phones around 11:10 a.m. and received a call from a Doctor at the hospital. The Doctor requested to speak with the Nurse assigned to care for Resident #E and she then went to the floor and informed LPN #3 the hospital Physician was calling. The Unit Director indicated she remained present while Nurse talked to the Physician and overheard the LPN telling the Physician of course she would have cleaned the sheets.</p> <p>When interviewed on 7/16/15 at 8:40 a.m. Laundry Aide #1 indicated she noted a linen with blood on them in the bin in the soiled utility room on 7/4/15 at approximately 6:30 a.m. There was blood on the flat sheet, fitted sheet, and</p>			

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	<p>the pillow case. She indicated the blood was not dried The linens were rolled up and not in a bag. The Laundry Aide indicated she had heard some staff talking at the Nurses Station at that time and one staff had stated there had been sheets on the bed and when they went back there weren't.</p> <p>When interviewed on 7/16/15 at 11:15 a.m., the Director of Nursing indicated she had received a text from the Alzheimer's Director on 7/4/15 indicating the hospital had called the Nurse about concerns related to the injury and APS was being called.</p> <p>The facility Abuse Policy was reviewed on 7/14/15 at 10:00 a.m. The policy indicated the DNS (Director of Nursing Services) or the ED (Executive Director) were to ensure an appropriate investigation was completed. The investigation was to included interview with employees, visitors, or residents who may have had knowledge of the incident.</p> <p>This Federal tag relates to Complaint IN00177395.</p> <p>3.1-28(d)</p>			

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the Abuse Policy was followed related to staff reporting accurate information related to which staff member first observed a resident with an injury of unknown origin and failed to interview ancillary staff related to hospital Physician concerns about linens for 1 of 3 Abuse Investigations reviewed. (Resident #E) (LPN #3)</p> <p>Finding includes:</p> <p>The closed record for Resident #E was reviewed on 7/13/15 at 3:20 p.m. The</p>	F 0226	<p>It is the intent of this facility to ensure the Abuse Policy is followed related to staff reporting accurate information.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p>No residents were identified as this was a complaint survey.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p>	08/15/2015

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	<p>resident's diagnosis included, but were not limited to, diabetes mellitus, dementia, high blood pressure, chronic pain, and foot fracture.</p> <p>The 7/2015 Physician orders were reviewed. An order was written on 7/4/15 to send the resident to the hospital Emergency Room for an evaluation and treatment.</p> <p>The 7/3/15 Nursing Progress Notes were reviewed. The last entry made on 7/3/15 was at 10:21 a.m. This entry indicated the resident was in bed with her eyes closed and was aroused without difficulty to verbal stimuli. The entry also indicated no acute distress was evident at this time.</p> <p>The 7/4/15 Nursing Progress Notes were reviewed. The first entry was entered at 8:30 a.m. This entry was a SBAR-Change of Condition note. The note indicated the LPN entered the resident's room to administer morning medications and noted an open area to the resident's left forehead with no frank bleeding noted. A large amount of dried sanguineous (red drainage usually from trauma of a blood vessel) drainage was noted around the area and in the residents hair and on her hands. The area measured 3.1 cm (centimeters) x 1.0 cm</p>				<p>All residents have the potential of being affected by this alleged deficient practice. Staff was in-serviced on the guidelines and importance of reporting any suspected or alleged abuse/neglect, including injury of unknown origin for a dependent resident. The Facility Management team was in-serviced on facility policy involving investigations. While the facility cannot control what information is reported by staff during interviews, staff were in-serviced on the importance of immediately reporting all facts as they can accurately recall, and to report any additional facts that they may not have recalled during the initial interview as timely as possible.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>While this facility followed best practices in this investigation of notifying State Agencies, local police department, Corporate Compliance and utilizing outside legal service and local detectives in the interview process; this facility re-educated staff on the importance of reporting any forms of abuse/neglect and gathering and documenting of information relating to an event. Facility compliance officer/designee will oversee investigations for</p>		

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	<p>x 0.2 cm. Light bruising was noted to the resident's left temple measuring 5.5 cm x 5.0 cm with no swelling noted. The writer had passed by and looked into the room several times prior and the area and the drainage were not visible from the doorway. The resident was alert and talking in her usual manner and when asked what happened responded "Oh I love you, I love you, I'm sorry, I'm sorry." The entry also noted the resident was bed/chair ridden and had bilateral leg immobilizers. The areas were cleansed with normal saline and covered with a foam dressing. An entry made at 9:30 a.m., indicated the ambulance arrived and the resident was transported to the hospital.</p> <p>A facility report of the 7/4/15 incident was reviewed. The report indicated on 7/4/15 the Nurse entered the resident's room to administer medications. The resident was in bed and an open area was noted to the resident's left forehead area with bruising noted to the left temple area also. The laceration measured 3.1 cm x 1.0 cm x 0.2 cm. The bruise measures 5.5 cm x 5.0 cm . A large amount of dried blood was noted around the open area.</p> <p>A 7/4/15 hospital Consult note indicated the hospital spoke with the patient's</p>		<p>injuries of unknown origin to assure these investigations are complete and corporate oversight is initiated if needed. Data Quality Improvement (DQI) will be reviewed in Clinical review meetings to verify investigation is thorough and complete.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>Open investigations will be reviewed in QAA for recommendations. QAA will monitor monthly for 90 days or until 100% compliance is obtained. <b>Date systemic changes will be completed: 8/15/2015</b></p>		

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	<p>Nurse at the Nursing Home to discuss the case and the Nurse indicated the resident was found with a large gash to her head with dried blood and the resident was cleaned up immediately. The Nurse also indicated she suspected the event occurred overnight before shift change.</p> <p>The report of the investigation of the injury for Resident #E was reviewed. The report indicated the Administrator was informed of the injury of unknown origin on 7/4/15. The initial report indicated the resident had a laceration to the left upper forehead and at the time no bruising or other indicated of injury were noted. The report indicated officers from the Police Department met with the facility Administrator and they went to the resident's room. The report indicated the Police returned to the facility on 7/10/15 and indicated they were continuing the investigation as a criminal investigation as there was an open question as to who removed the soiled linens from the bed.</p> <p>The facility Administrator and the DON (Director of Nursing) were interviewed on 7/14/15 beginning at 6:55 a.m. The DON indicated she was notified on 7/4/15 and it was reported the Day shift Nurse was the first person to see the resident and called for help. The resident</p>			

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	<p>was sent to the Emergency Room. The Unit Manager conducted staff interviews on 7/4/15. The DON indicated the night shift CNA was suspended on 7/4/15 as she was the last one noted to have provided care for the resident. The DON indicated the night CNA's interview indicated she last provided incontinence care to the resident by herself at approximately 5:45 a.m. The CNA was noted to have clocked out at 6:38 a.m. on 7/4/15.</p> <p>The facility Administrator indicated Laundry Aide #1 was interviewed on 7/6/15 as she was reported to have picked up laundry bins on the resident's unit at 6:30 a.m. on 7/4/15 and reported noting bloody linens on the unit.</p> <p>The DON indicated a Housekeeping staff member was interviewed on 7/6/15 and reported having seen spots on blood on the residents room floor, on the chair, and on the floor between bed and the bathroom and on the resident.</p> <p>The Unit Manager was interviewed on 7/14/15 at 10:15 a.m. The Unit Manager indicated on 7/4/15 the day shift Nurse called her and informed her she had found the resident at 8:29 a.m. with blood on her face and her hands. The Unit Manager indicated the next day she found</p>			

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	<p>out that the Nurse had been called into the room by the Housekeeper who had reported she saw the resident's in her room with blood on her. The Unit Manager indicated if she had been notified the Housekeeper was the first to see the resident the Housekeeper could have been interviewed on 7/4/15.</p> <p>The facility Administrator, DON and Unit Manager were interviewed on 7/15/15 at 11:15 a.m., the Unit Manger indicated she had been mistaken related to the day the day Nurse reported to her that it was the housekeeper who first observed the resident on 7/4/15. The Unit Manager indicated this information was reported to her first on 7/6/15 and not 7/5/15 as per the previous interview. The Unit Manager indicated she had not spoken to the Housekeeper on Monday (7/6/15).</p> <p>When interviewed on 7/16/15 at 10:20 a.m. the Alzheimer Unit Director indicated she was the Unit Manager on Duty on the 4th. The Manager indicated she was answering phones around 11:10 a.m. and received a call from a Doctor at the hospital. The Doctor requested to speak with the Nurse assigned to care for Resident #E and she then went to the floor and informed LPN #3 the hospital Physician was calling. The Unit Director</p>			

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	<p>indicated she remained present while Nurse talked to the Physician and overheard the LPN telling the Physician of course she would have cleaned the sheets.</p> <p>When interviewed on 7/16/15 at 8:40 a.m. Laundry Aide #1 indicated she noted a linen with blood on them in the bin in the soiled utility room on 7/4/15 at approximately 6:30 a.m. There was blood on the flat sheet, fitted sheet, and the pillow case. She indicated the blood was not dried The linens were rolled up and not in a bag. The Laundry Aide indicated she had heard some staff talking at the Nurses Station at that time and one staff had stated there had been sheets on the bed and when they went back there weren't.</p> <p>When interviewed on 7/6/15 at 11:15 a.m., the Director of Nursing indicated she had received a text from the Alzheimer's Director on 7/4/15 indicating the hospital had called the Nurse about concerns related to the injury and APS was being called.</p> <p>The facility Abuse Policy was reviewed on 7/14/15 at 10:00 a.m. The policy indicated the DNS (Director of Nursing Services) or the ED (Executive Director) were to ensure an appropriate</p>			

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F 0309 SS=D Bldg. 00	<p>investigation was completed. The investigation was to included interview with employees, visitors, or residents who may have had knowledge of the incident.</p> <p>This Federal tag relates to Complaint IN00177395.</p> <p>3.1-28(d)</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. Based on record review and interview, the facility failed to ensure the necessary treatment and services were provided related to completing blood sugars and</p>	F 0309	It is the intent of this facility to ensure the necessary treatment and services are provided relating to completing blood sugars and administering Insulin per the	08/15/2015	

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	<p>administering Insulin per the sliding scale scale for 1 of 3 residents reviewed for Insulin administration in a sample of 14. (Resident #F)</p> <p>Finding includes:</p> <p>The record for Resident #F was reviewed on 7/13/15 at 1:00 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus.</p> <p>A Physician's order was written on 6/4/15 for Blood Glucose monitoring to be completed three times a day at 7:00 a.m., 11:00 a.m., and 4:00 p.m. There were also orders for Novolog insulin to be administered per sliding scale coverage as follows: 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351-400 = 10 units 401 and above - Notify the Physician.</p> <p>The 6/2015 Medication Administration Record was reviewed. There was no record of Blood Glucose monitoring or Insulin administration for the following dates and times: 6/10/15 at 7:00 a.m. and 11:00 a.m. 6/13/15 at 7:00 a.m. 6/14/15 at 4:00 p.m.</p>		<p>sliding scale. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b> No residents were identified as this was a complaint survey. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents with a diagnosis of Diabetes with Insulin sliding scale orders have the potential to be affected by this alleged deficient practice. Licensed nursing staff has been re-educated on the importance of following Physician orders and guidelines pertaining to Glucose testing, administration of Insulin, Physician notification and documentation of resident refusal when applicable. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> The DNS/Unit Manger/designee will complete weekly audits of MARs for up to 5 residents per unit that have orders for Glucose testing and insulin to assure complete documentation is in place as per guidelines. Licensed nursing staff in non-compliance will be re-educated on guidelines. Continued non-compliance will result in progressive discipline action as per company</p>				

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F 0314 SS=D Bldg. 00	<p>6/16/15 at 7:00 a.m. and 11:00 a.m. 6/19/15 at 4:00 p.m. 6/29/15 at 11:00 a.m.</p> <p>The resident's Care Plans were reviewed. A Care Plan initiated on 2/24/2011 indicated the resident was at risk for glycemic reactions related to a diagnosis of Diabetes Mellitus. The Care Plan was last updated with a goal date of 8/31/15. Care Plan interventions included for medications to be administered as ordered.</p> <p>When interviewed on 7/15/15 at 11:00 a.m. the Director of Nursing indicated the blood glucose levels and insulin administration should have been completed as ordered.</p> <p>This Federal tag relates to Complaint IN00176471.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were</p>				<p>guidelines. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> Audit results of Insulin administration will be presented to QAA for recommendations for an action plan as needed. QAA will monitor monthly for 6 months and quarterly for 2 quarters. <b>Date systemic changes will be completed:</b> 8/15/2015</p>		

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	<p>unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the necessary treatment a services were provided for residents with pressure ulcers related to weekly skin assessments not completed and failure to initiate treatments for new pressure ulcers in a timely manner for 2 of 4 residents reviewed for pressure ulcers in a sample of 14. (Residents #E and #F) (CNA #1)</p> <p>Findings include:</p> <p>1. On 7/13/15 at 1:15 p.m., Resident #F was observed in bed. CNA's #1 and #2 were providing incontinence care for the resident. An open area was observed on the resident's right upper inner thigh area. The area measured approximately 2.5 x 2.5 cm (centimeters). The center of the open area was red. The Unit Supervisor was present at this time.</p> <p>The record for Resident #F was reviewed on 7/13/15 at 1:00 p.m. There resident's diagnoses included, but were not limited to diabetes mellitus. The current Physician orders were reviewed. There were no Physician orders for any treatments to the open area noted.</p>	F 0314	<p>It is the intent of this facility to ensure necessary treatment and services are provided for residents with pressure ulcers, complete weekly skin assessments and initiate treatments for new pressure ulcers in a timely manner.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p>No residents were identified as this was a complaint survey.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All resident's have the potential of being affected by this alleged deficient practice. A skin sweep was completed throughout the facility on 7/10/15. Physician was notified on any new areas, treatment and family notification was also verified. A second skin sweep was completed on 7/17/15 with no new issues identified. Facility audited the SBAR for resident's identified as having pressure ulcers to assure Physician</p>	08/15/2015

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	<p>A Wound Evaluation Flow Sheet was initiated on 7/13/15. The sheet indicated a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough) pressure ulcer was noted to the resident's right inner thigh. The area measured 2 cm x 2 cm.</p> <p>When interviewed on 7/13/15 at 1:30 p.m., CNA #1 indicated the resident had a history of open areas. The CNA indicated she changed the resident earlier in the morning after breakfast and first noted the open area at that time. The CNA indicated she did not inform the Nurse of the new open area at that time.</p> <p>When interviewed on 7/13/15 at 1:45 p.m., the Unit Supervisor indicated the area noted the resident's upper thigh was a pressure ulcer and new Wound Evaluation form was completed and a new order was obtained to apply Calazine ointment to the area every shift.</p> <p>2. The closed record for Resident #E was reviewed on 7/13/15 at 3:20 p.m. The resident's diagnosis included, but were not limited to, diabetes mellitus, dementia, high blood pressure, chronic pain, and foot fracture.</p>		<p>notification was completed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The DNS/unit manager/designee will review SBAR's in clinical review meetings to assure that notification of Physician and treatment orders are implemented timely and review weekly skin check/shower sheets for indications of new pressure ulcers. Any Nursing staff in non compliance of timely notification will be re-educated on guidelines. Continued non-compliance will result in progressive discipline action as per company guidelines.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>Results of the SBAR audits will be presented to the QAA with noted trends. The QAA will make recommendations to the Action Plan as needed. QAA will monitor monthly for 6 months and quarterly for 2 quarters .</p> <p><b>Date systemic changes will be completed: 8/15/2015</b></p>		

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	<p>The 4/15/15 Minimum Data Set (MDS) admission assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident required extensive assistance of one staff member for bed mobility, personal hygiene, and dressing. The assessment indicated the resident was incontinent of bowel and bladder. The assessment also indicated the resident was at risk for pressure ulcer development.</p> <p>A Wound Evaluation Flow Sheet initiated on 4/18/15 indicated an ulcer to the right outer ankle was observed. The pressure ulcer was noted to be a Stage II( partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough) ulcer. The pressure ulcer measured 2.5 cm x 1 cm with no exudate. The wound margins were uneven and the surrounding tissue was intact.</p> <p>A Physician's order dated 4/21/15 at 3:26 a.m. was reviewed. The order was to cleanse the Stage II wound to the right outer ankle with normal saline, apply Silvadene 1% Cream, and cover the ulcer with a dry dressing daily and prn (as</p>			

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	<p>needed) for soilage or detachment. There were no Physician order written or obtained on 4/18/5 or 4/19/15 for any treatment on the new pressure ulcer to the ankle.</p> <p>The 4/2015 Treatment Administration Record was reviewed. The above ordered treatment to the right outer ankle pressure ulcer was first signed out as completed on 4/21/15 at 8:00 a.m.</p> <p>When interviewed on 7/16/15 at 2:50 p.m., the Unit Manager indicated the right ankle pressure ulcer was first observed on 4/18/15 and the Physician should have been notified at the time the ulcer was first observed to obtain orders to treat the ulcer. The Unit Manager indicated the treatment to the pressure ulcer was initiated on 4/21/15. The Unit Manager also indicated Nursing staff were to complete weekly skin assessments and no weekly skin assessment prior to the development of the ankle ulcer was noted.</p> <p>When interviewed on 7/16/15 at 9:43 a.m., the Director of Nursing indicated weekly skin checks were to be completed by Nursing staff for all residents as part of the facility pressure ulcer prevention protocol.</p>			

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F 0441 SS=D Bldg. 00	<p>The facility policy titled "Prevention of Pressure Ulcer" was reviewed on 7/15/15 at 10:05 a.m. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated notification of the Physician was required when a new pressure ulcer was identified.</p> <p>This Federal tag relates to Complaints IN00177395 and IN00177997.</p> <p>3.1-40(a)(2) 3.1-40(a)(3)</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 resident; and</p>				

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	<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 and interview, the facility failed to provide a sanitary environment to prevent the spread of infection related to personal use plastic wash basins and urine collection containers stored uncovered on bathroom floors in 3 rooms on the C hall and an uncovered laundry bin in the hallway. (Rooms 212, 221, and 225)</p> <p>Findings include:</p> <p>1. On 7/14/15 at 4:50 a.m., an uncovered white plastic container used to place under the toilet set to collect urine was observed on the floor in the bathroom of</p>	F 0441	<p>It is the intent of this facility to provide a sanitary environment to prevent the spread of infection related to storage of plastic wash basins and urine collection containers. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b> No residents were identified as this was a complaint survey. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential of being affected by this alleged deficient practice. Facility</p>	08/15/2015

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	<p>Room 221 between the sink and the toilet. The urine container was not covered. No resident name was written on the container. Two residents resided in this room</p> <p>2. On 7/14/15 at 4:52 a.m., an uncovered gray plastic wash basin was observed on the floor in the bathroom of Room 212. The basin was not in a bag or covered. There was no resident name on the basin. Two residents resided in this room.</p> <p>3. On 7/14/15 at 5:11 a.m., an uncovered gray plastic wash basin was observed on the floor in the bathroom of Room 225. The basin was not in a bag or covered. There was no resident name on the basin. Two residents resided in this room.</p> <p>When interviewed on 7/15/15 at the Director of Nursing indicated she could not locate a policy related to the storage of the basins and urine containers. The Director of Nursing indicated they were all to be labeled with the resident's name and covered. The Director of Nursing also indicated the containers and basins should not have been left on the bathroom floors.</p> <p>4. On 7/14/15 at 4:30 a.m., a large yellow rolling linen cart was observed at</p>		<p>managers/Guardian Angels and nursing staff were in-serviced on facility guidelines for storage of plastic basins and urine collection containers. Facility managers/Guardian Angels were re-educated on the Guardian Angel program guidelines. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Facility Managers/Guardian Angels will observe resident rooms for compliance of storage of basins and urinals. Rooms in non compliance will be corrected immediately and direct care staff will be re-educated as needed. Housekeeping was in-serviced on proper storage of basins and urinals on 8/24/15. Executive Director/designee will review Guardian Angel reports weekly for areas of non compliance. Results of these reviews will be reported to QAA for further recommendations. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> Results of Guardian Angel and Housekeeping rounds will be presented to QAA for tracking and trending. The QAA will make recommendations to the Action Plan as needed. QAA will monitor monthly for 6 months and quarterly for 2 quarters . <b>Date</b></p>		

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F 0465 SS=D Bldg. 00	<p>the end of the middle hall. There was no cover on the cart. Used and dirty linen/clothing items were noted in the cart. No night shift staff members were observed placing soiled linens into this cart.</p> <p>When interviewed on 7/14/15 at 8:00 a.m. the facility Administrator indicated the bin was one which was used by Laundry and was not to left uncovered on the unit.</p> <p>This Federal tag relates to Complaints IN00176471 and IN00177742.</p> <p>3.1-18(a)</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, record review, and interview, the facility failed to ensure the resident's environment remained sanitary and comfortable related to marred and chipped walls, doors, and tables in resident rooms, dirty privacy curtains and dried food spillage on floor and poles, dust accumulation on ceiling vents, and</p>	F 0465	<p><b>systemic changes will be completed: 8/15/2015</b></p> <p>It is the intent of this facility to ensure the resident's environment remains sanitary and comfortable related to resident room walls, doors, tables, privacy curtains, floors, poles, ceiling vents and register covers.</p> <p><b>What corrective action(s) will be</b></p>	08/15/2015

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	<p>register covering not in place or loose on 1 of 3 Units. ( Unit C )</p> <p>Findings include:</p> <p>The following was observed on Unit C during observations between 4:30 a.m. - 5:45 a.m.</p> <p>1. Room 220- (One resident resided in this room) A section of the plaster board was behind the toilet was missing in the bathroom. The paint on the bathroom door frame was chipped on both sides. The wall across from the foot of the Bed 1 was marred.</p> <p>2. Room 214 ( One resident resided in this room) The paint and plaster board around the toilet was peeling in the bathroom. The paint on the bathroom door frame was chipped on both sides. There was an accumulation of dust on the ceiling vent in the bathroom. The cove base by the bathroom sink was loose. The wall was marred under the call light box. There was dried spillage on the legs of the tube feeding pole and on the floor around the pole stand.</p> <p>3. Room 221 (Two residents resided in this room)</p>		<p><b>accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p>The bathroom door frames were repainted for rooms 220, 214, 221, 218.</p> <p>The bathroom walls, toilet areas were repaired/painted for rooms 220, 214, 212, 218, 225.</p> <p>The resident room walls were repaired/painted for rooms 220, 214, 213.</p> <p>Bathroom ceiling vents were cleaned for rooms 214, 221, 212, 218.</p> <p>The wall register vent cover was replaced for room 224.</p> <p>The privacy curtains in room 225 were cleaned.</p> <p>Spillage areas were cleaned in rooms 214, 225.</p> <p>The over bed table in room 233 was replaced. .</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this alleged deficient practice. Facility staff have been</p>		

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	<p>The paint on the bathroom door frame was chipped. There was an accumulation of dust on the bathroom ceiling vent.</p> <p>4. Room 212 (Two residents resided in this room) The cove base in the bathroom was missing. There was an area of the wall behind and under the toilet which was peeled away and dark in color. Dark brown spots were on this section. There was dust on the ceiling vent in the bathroom</p> <p>5. Room 213 (Two residents resided in this room) The walls were marred and the paint was chipped on the wall across from Bed-1.</p> <p>6. Room 218 (One resident resided in this room) The paint on the bathroom door frame was chipped. The caulking around the toilet was peeling. There was dust on the ceiling vent in the bathroom.</p> <p>7. Room 224 (Two residents resided in this room) There was a cover piece missing on the end of the wall register vent. Coils were visualized where the cover piece was missing.</p>		<p>in-serviced on the process of initiating a work order for any needed repairs observed. Plant operations staff have developed a schedule for repair/painting of resident rooms and resident bathrooms. Housekeeping staff were in-serviced on routine cleaning procedures to include inspection/cleaning of ceiling vents and privacy curtains and handling soiled linen on units. Nursing staff were in-serviced on care/cleaning of nursing equipment in reference to IV/feeding tube poles and equipment.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>Plant operations will continue with resident room refurbishments. The Plant Operation Director/designee will review with the Executive Director/designee weekly, rooms to be scheduled for repair and painting. Housekeeping Supervisor/designee will complete weekly audits of resident rooms to assure proper cleaning of rooms is completed. Nursing management/designee will inspect nursing equipment located in resident rooms for repair and cleanliness. Any concerns of non-compliance will be corrected immediately; a repair order generated as necessary and the</p>	

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F 0502 SS=D Bldg. 00	<p>8. Room 225 (Two residents resided in this room) The caulking behind the toilet was peeling. There was spillage on the wall in the bathroom. The spillage was noted next to the garbage can. The bottom of the privacy curtain between the two beds was dirty.</p> <p>9. Room 233 (Two residents resided in this room) The legs and bottom bars of the overbed table for Bed 1 were all chipped and appeared rusty.</p> <p>Maintenance Staff #1 was informed of the above areas on 7/14/15 at 11:00 a.m. and indicated the above areas were in need of repair or cleaning.</p> <p>This deficiency relates to Complaint IN00176471.</p> <p>3.1-19(f)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and</p>		<p>Executive Director/designee will be notified of plan to correct non compliance concerns.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>QAA will continue to monitor for trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for 90 days or until 100% compliance is obtained.</p> <p><b>Date systemic changes will be completed:</b> 8/15/2015</p>	

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	<p>timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were completed as ordered related to a urine specimen not collected by staff for laboratory testing to be completed for 1 of 3 residents reviewed for Urinary Tract Infections in a sample of 14. (Resident #E)</p> <p>Finding include:</p> <p>The closed record for Resident #E was reviewed on 7/13/15 at 3:20 p.m. The resident's diagnosis included, but were not limited to, diabetes mellitus, dementia, high blood pressure, chronic pain, and foot fracture.</p> <p>The 4/15/15 Minimum Data Set (MDS) admission assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident required extensive assistance of one staff member for bed mobility, personal hygiene, and dressing. The assessment indicated the resident was incontinent of bowel and bladder.</p> <p>The July 2015 Physician orders were reviewed. An order for a Urinalysis and</p>	F 0502	<p>It is the intent of this facility to ensure laboratory tests are completed as ordered related to urine specimens.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</b></p> <p>No residents were identified as this was a complaint survey.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents with an order for a Urinalysis and Culture and Sensitivity could be affected by this alleged deficient practice. An audit was completed to determine any residents who have received orders for lab orders of urine specimens for completion for the prior 7 days. No other incomplete orders were noted.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>Nursing staff were in-serviced on procedures for completing a urine lab order and follow up</p>	08/15/2015			

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	<p>Culture and Sensitivity was obtained on 7/1/15 at 1:24 p.m.</p> <p>The 7/2015 Laboratory tests results were reviewed. There was no documentation of the the ordered Urinalysis and Culture and Sensitivity test being completed.</p> <p>When interviewed on 7/14/15 at 9:39 a.m., the Unit Manager indicated the Urinalysis test had not been completed. The Unit Manager indicated the Laboratory staff was at the facility five days a week to pick up specimens. The Unit Manager indicated the urine specimen should have been collected and then could have been picked up by Laboratory staff on 7/2/15 or 7/3/15.</p> <p>This Federal tag relates to Complaint IN00177395 and IN00177742.</p> <p>3.1-49(a)</p>		<p>documentation of submission and results of lab requests. Physician orders for urine lab requests will be reviewed during clinical review meetings to assure compliance. Any concerns of non-compliance will be notified to DNS/designee, Physician and family. Non-compliance concerns will be reported to QAA for further recommendations.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>QAA will continue to monitor for trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for 90 days or until 100% compliance is obtained.</p> <p><b>Date systemic changes will be completed:</b> 8/15/2015</p>		