STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	11/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 14, 15, 16 and 17, 2017 Facility number: 000463 Provider number: 155444 AIM number: 100290910 Census Bed Type: SNF/NF: 19 SNF: 0 NF: 0 Total: 19 Census Payor Type: Medicare: 1 Medicaid: 15 Private: 1 Other: 2 Total: 19 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on November 28, 2017.	F 0000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.	
F 0156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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Bldg. 00	CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services			

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	where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;			

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	[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of			

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	resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included			

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	in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or			

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	reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide an appropriate liability and appeal notice for 1 of 3 residents reviewed for liability notices and beneficiary appeal rights review. (Resident 29) Findings include: A clinical record review for Resident 29 was completed on 11/17/17 at 10:00 a.m., the resident was discharged on 6/13/17. Review of Liability and Appeal Notice Letters, completed on 11/15/17 at 9:00 a.m., indicated there was no letter for Resident 29. On 11/17/17 at 9:28 a.m., the Business Office Manager (BOM) indicated that she was unable to locate the Liability and Appeal Notice for Resident 29.	F 0156	F 156 Resident #29 discharged from the facility on 6/13/17 Other residents who have had a Medicare stay have potential to be affected by the alleged deficient practice. A review of residents who have had a Medicare stay in the last 30 days were reviewed to ensure the appropriate liability and appeal notice was provided. Business Office Manager and Social Service Director were re-educated on providing appropriate liability and appeal notices by Executive Director on 12/8/17. Review of residents discharging from Medicare stay will be conducted by Business Office Manager 5 times a week for 8 weeks, then 3 times a week for 8 weeks, then weekly for 2 months to ensure appropriate liability and appeal notices are provided. Results of review will be taken to Quality Assurance Performance Improvement Committee monthly	12/17/2017

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	A current facility policy, dated 1/1/08 and revised 1/1/08, titled "Medicare Notice of Non-Coverage" was provided by the Business Office Manager on 11/17/17 at 10:54 a.m., and indicated the following: "Policy: To inform the Medicare beneficiary or representative of the denial or discontinuation of Part A/Part B Medicare benefits either upon admission to the facility or during the beneficiary's stay. ...the denial letter when the facility PPS/UR committee has determined non-coverage during the Medicare stay." 3.1-4 (f)(3)		for 6 months for further review or recommendations. Compliance will be determined based on results of audits	
F 0159 SS=A Bldg. 00	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In			

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	pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident’s			

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	account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on interview and record review, the facility failed to ensure residents had access to their personal funds accounts at all times for 2 of 4 residents reviewed for personal funds (Resident 15 and 23). Findings include: During an interview with Resident 15, on 11/14/17 at 10:43 a.m., she indicated she could only get money out of her person funds account when the window was opened and if it was not she would have to go back later. MDS (Minimum Data Set) Assessment, dated 8/24/17, indicated Resident 15 had a BIMS (brief interview for mental status) score of 15. This indicated she was cognitively intact. During an interview with Resident 23, on 11/14/17 at 1:47 a.m., she indicated she could only get money out of her person funds account when the office was opened.	F 0159	F159 Residents with personal funds who have provided written authorization for the facility to manage their funds are potentially affected by the alleged deficient practice. A corrected posting has been displayed at the main area, stating access to funds at any time and contact individuals noted. Responsible Parties have been notified by letter, mailed out 12/15/17 of the policy regarding access to funds. Resident #15, Resident #23, and other Residents who are responsible for self will be re-educated by 12/16/17 by the Administrator that their funds are accessible at all times, and the method for access. The Business Office Manager and Charge Nurses will be re-educated on the expectation of no denial of access of funds to be made at any time. Business Office Manager will ensure reasonable funds are accessible to the Charge Nurse to ensure resident access for the times of her absence. The Activities Director will monitor compliance with providing	12/17/2017

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	MDS (Minimum Data Set) Assessment, dated 9/5/17, indicated Resident 23 had a BIMS (brief interview for mental status) score of 15. This indicated she was cognitively intact. During an interview with the Business Office Manager, on 11/15/17 at 1:43 p.m., she indicated the residents could get money out of their personal funds accounts during banking hours. These hours were posted as Monday thru Friday from 8:00 a.m. - 4:30 p.m. On the weekends and holidays the charge nurse at the 100 Hall nurse station had $100.00 and the residents could receive monies through her from the hours of 9:00 a.m. - 12:00 p.m. A policy titled "Resident Trust", dated 8/1/09, was provided by the Business Office Manager, on 11/15/17 at 2:20 p.m. This policy indicated "...this will allow the resident to have access to their funds when requested....". 3.1-6(f)(1)		information on immediate access to personal funds during Resident Council each month for six months to ensure all Residents are aware of their access. Results of resident council meetings will be taken to Quality Assurance Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of resident council meeting reviews.	
F 0253 SS=D Bldg. 00	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary,			

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	orderly, and comfortable interior; Based on observation and interview, the facility failed to keep resident rooms and hallways free from holes in the walls and gashes on the doors for 3 of 8 rooms on the 100 Hall and 1 of 1 Lounge areas (Rooms 105, 106, 108 and 300 Hall Lounge). Findings include: During the Initial Tour on 11/17/17 at 9:19 a.m.; Room 105-B had large gashes on the bath room door. Room 106-B had more than 10 holes in the around the bathroom walls; 4 holes had been spackled over by the bathroom door without sanding or painting. Room 108-B had large gashes on the bathroom door. The resident lounge off of the 300 Hall was also noted to have large gashes on the walls and around the interior doorway. During the Environmental Tour with the Administrator, Housekeeping Supervisor and the Maintenance Director on 11/17/2017 at 11:08 a.m., the	F 0253	F253 Room numbers 105, 106, 108, and lounge area were repaired by Maintenance Director by 12/1/17. A part was ordered for room number 300 by Maintenance Director on 12/7/17. Other building areas with holes or gashes have the potential to affect other residents residing in the facility. Environmental rounds were conducted by Maintenance Director on 12/11/17 with repairs conducted as needed. Maintenance Director was re-educated about repairing holes/gashes in doors by the Executive Director on 12/12/17. Environmental rounds will be conducted by Maintenance Director of occupied resident rooms 3 times a week for 12 weeks, then weekly for 12 weeks to ensure resident rooms and hallways with holes in walls and gashes on doors will be repaired timely. Repairs will be made as needed. Results of rounds will be taken to Quality Assurance Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of audits.	12/17/2017

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	Maintenance Director indicated that he did know about holes in the wall in room 106-B; however he had not checked room 105-B, 108-B and had not noticed the Lounge off of the 300 Hall. On 11/17/2017 at 11:19 a.m., the Maintenance Director indicated that he does not have a policy for room painting; he just randomly picks rooms to work on based on the availability and accessibility of the rooms. He indicated that he randomly visually inspects the rooms and see what needs to be painted. 3.1-19(f)(5)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the			

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	effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	(D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, interview, and record review, the facility failed to revise the plan of care with individualized interventions to promote the healing of, and to prevent the further development of, skin breakdown for 1 of 1 residents reviewed for pressure ulcers developed after admission (Resident 18). Findings include: On 11/14/17 at 1:25 p.m., Resident 18 was in her room, sitting in her recliner. She was wearing a pair of white athletic shoes on her feet, which were elevated on the recliner. She indicated she had	F 0280	F280-- Resident 18 CP reviewed and updated by D.O.N/Designee to reflect appropriate interventions on 11/17/17. Residents living at facility could have the potential to be affected by this alleged deficient practice. Careplans of Residents with pressure ulcers were reviewed by D.O.N/Designee with intervention(s) updated as needed on 12/8/17. Nurses were re-educated regarding appropriate pressure ulcer interventions by D.O.N/designee on 11/21/17.	12/17/2017

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	recently bought the shoes, since the nurses told her the previous pair had caused sores on her feet. On 11/16/17 at 11:07 a.m., she was in her room, sitting in her recliner. She was wearing a pair of socks and slippers on her feet. On 11/17/17 at 8:15 a.m., she was in her room, sitting in her recliner. She was wearing a pair of white athletic shoes on her feet. Review of the clinical record began on 11/14/17 at 2:08 p.m. Diagnoses included, but were not limited to, end stage renal disease, hypertension, repeated falls, and diabetes. A 10/12/17, quarterly, MDS assessment indicated she was cognitively intact, required supervision and set up with dressing and extensive assistance with personal hygiene. The assessment indicated she had two unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcers. She had a current careplan problem of a self-care deficit and needed physical		D.O.N/Designee to perform care plan reviews of residents with pressure ulcers weekly for 12 weeks, then every other week for 12 weeks to ensure interventions to promote the healing of and prevent the further development of skin breakdown are in place. Audits from DON/Designee will be brought to Quality Assurance Performance Improvement Committee monthly for 6 months for further review and or recommendations. Compliance will be determined based on results of audits.	

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	assistance of one person with ADLs and dressing. She had a current careplan problem of a potential for impaired skin integrity. Interventions included, but were not limited to, lotion, cushion use, bath per schedule and evaluate skin weekly. She had a current careplan problem of an actual skin impairment to her left 5th digit. Interventions included, but were not limited to, identify causes and resolve when possible, non-skid socks, and weekly assessment. A 10/3/17 Nurse Practioner exam note indicated it appeared as if her new shoes were causing pressure to her toes, resulting in necrotic (dead) tissue bilaterally. An order was written for her to be taken to an orthopedic shoe store to be evaluated for therapeutic shoes. A 10/31/17 Social Services note indicated she had been fitted for diabetic shoes and they should be in by Thanksgiving. During an interview, beginning on 11/17/17 at 9:46 a.m., the DON indicated the resident had received the order for an evaluation for specialty shoes on 10/3/17, but had not had it completed due to an			

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	issue with insurance, and had not been evaluated until 10/31/17 by another specialty shoe company. She indicated the resident had been encouraged to wear slippers instead of shoes, but she preferred shoes when she left the building for dialysis and other activities. She indicated she had not seen the resident's new shoes and the shoes had not been addressed in her care plan. Review of a policy, titled "Skin Integrity," dated August 2014, and provided by the Nurse Consultant on 11/16/17 at 3:11 p.m., indicated the following: "...Residents identified to be at risk for skin breakdown (pressure ulcers) will have a routine assessment and interdisciplinary (IDT) care plan process implemented to maintain and/or improve skin integrity. The objective is to create an on-going process to identify and actively manage risk and/or skin integrity issue(s), and to determine appropriate referrals or interventions to achieve positive clinical outcomes...." The policy indicated care plans were to be revised as appropriate and facility practices would be evaluated to determine changes needed to reduce, eliminate, and heal pressure ulcers. 3.1-35(d)(2)(B)			

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F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. A. Based on observation, interview, and record review, the facility failed to ensure residents received insulin in a timely manner as ordered to manage blood glucose management (Resident 19) and failed to ensure medications were administered at a time preferable to residents to promote medication compliance (Resident 23). B. Based on observation, interview, and record review, the facility failed to consistently implement careplanned interventions for oral hygiene for 1 of 1 residents reviewed for dental services (Resident 8). Findings include: A.1. During a medication administration observation, on 11/15/17 at 9:50 a.m., RN 33 administered 100 units of Novolin 70/30 insulin to Resident 19, who was sitting in his wheelchair in his room.	F 0282	F282— Resident 19- 1:1 education with nurse 33 on Insulin Administration completed on 12/7/17. Nurses were re-educated to administer medications at a time preferable to resident #23 and care plan was revised by DON/Designee on 11/16/17. Resident 8 had a tooth brush supplied by CNA at the time of observation on 11/17/17. Residents with insulin dependent diabetes, preferences for medication administration and extensive assist with oral hygiene could have the potential to be affected by this alleged deficient practice. Care plans were revised as needed for these residents by Director of Nursing /Designee. Nurse education on the administration of medication and resident preferences for medication administration was conducted by D.O.N/Designee on 11/21/17. CNA education completed on oral care of dependent residents was conducted by DON on 11/21/17.	12/17/2017

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	Review of the clinical record began on 11/14/17 at 2:33 p.m. Diagnoses included but were not limited to, dementia, pneumonia, chronic kidney disease, insomnia, type 2 diabetes, COPD, depression, bipolar disorder, and anxiety. He had current medication orders for Novolin 70/30 100 units daily and 70 units at dinner, Regular insulin 15 units in the afternoon and 10 units at bedtime, Novolog insulin 10 units twice daily and per sliding scale before meals, and Victoza (diabetic medication) 1.8 mg daily. Review of progress notes indicated the following: On 9/19/17, the Nurse Practitioner (NP) noted elevated blood sugars and ordered to increase his Novolog to 15 units in afternoon until his endocrinologist appointment on 10/10/17. A 10/10/17 endocrinology NP note indicated elevated blood glucose readings, requiring an increase in his Triseba (long acting insulin). A 10/31/17 endocrinology NP note indicated to change the Triseba to Novolin 70/30 at breakfast and dinner.		D.O.N/Designee to perform audit on 5 residents medication administration with 2 residents being insulin dependent diabetics weekly for 4 weeks, then 3 residents medication administration with 1 resident being insulin dependent diabetic weekly for 4 weeks, then 3 resident medication administration with 1 resident being insulin dependent diabetic monthly for 4 months to ensure resident receives insulin and medications timely and preferences regarding medication administration are honored. D.O.N/Designee to perform random checks on 8 residents weekly for 4 weeks; that oral products are available and that oral care has been provided; 4 residents weekly for 4 weeks; 4 residents monthly for 4 months; to ensure oral care products are readily available and that oral care is provided to dependent residents Audits from DON/Designee will be brought to Quality Assurance Performance Improvement Committee monthly for 6 months for further review compliance will be determined based on results of audits.	

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	Review of November 2017 MARs indicated the following: He had received his breakfast dose of Novolin 70/30 insulin at the following times: On 11/9/17 at 8:43 a.m. On 11/11/17 at 8:37 am. On 11/15/17 at 9:58 a.m. He had received his supper dose of Novolin 70/30 insulin at the following times: On 11/4/17 at 6:33 p.m. On 11/14/17 at 6:45 p.m. On 11/15/17 at 8:50 p.m. He received his Novolog 10 units, ordered every 12 hours at 6 a.m. and 6 p.m., with the Novolin 70/30 on 11/15/17 at 8:50 p.m. He had received his Regular insulin, scheduled for 12 noon at the following times: On 11/2/17 at 1:48 p.m.			

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	On 11/11/17 at 1:54 p.m. He had received his Novolog sliding scale, ordered for before meals, at the following times: On 11/2/17 (lunch dose) at 1:36 p.m. and (supper dose) at 6:36 p.m. On 11/5/17 (supper dose) at 5:30 p.m. On 11/7/17 (lunch dose) at 12:40 p.m. On 11/11/17 (lunch dose) at 1:52 p.m. On 11/14/17 (supper dose) at 6:46 p.m. During an interview, on 11/16/17 at 1:33 p.m., the DON indicated she was not aware of the late administration times for Resident 19. Review of a policy titled "General Dose Preparation and Medication Administration," dated 12/1/07 and provided by the Nurse Consultant on 11/17/17 at 10:44 a.m., indicated to ensure medication was administered at the correct time. A.2. On 11/14/17 at 1:38 p.m., Resident 23 was observed in bed, with the TV on.			

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	On 11/16/17 at 8:16 a.m., she was in her doorway, with the call light on, she indicated to a staff member she was waiting to be assisted back to bed. On 11/17/17 at 8:21 a.m., she was in her room in her wheelchair, going through her bed side table. Review of the clinical record began on 11/14/17 at 2:42 p.m. Diagnoses included, but were not limited to, CVA (stroke), major depressive disorder, pain, hypertension, anxiety, and low back pain. She had current medication orders for, but not limited to, lisinopril (blood pressure) 10 mg once daily, Buspar (anti-anxiety) 5 mg in the a.m. and afternoon, and 10 mg at bedtime, Depakene (either for seizures or mood stabilization) 250 mg in a.m. and 500 mg at bedtime, hydrochlorothiazide (water pill) 25 mg once daily, spironolactone (water pill) 25 mg once daily, metoprolol tartrate (blood pressure) 25 mg once daily, Levoxyl (thyroid) 50 mcg once daily, and clopidogrel (blood thinner) 75 mg once daily. A 9/5/17, quarterly, Minimum Data Set (MDS) assessment indicated she was cognitively intact and had no behaviors.			

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	A 10/20/17 Behavior Management meeting note indicated behaviors were reported 10/22 and 10/23 of refusing to take medications because they made her sick to her stomach. A Social Services note, dated 11/3/17, indicated the resident told her she was not refusing medications, she just didn't think she could keep them down due to not feeling well. An 11/7/17 psychologist note indicated she complained of gagging when taking her medications and recommended discussing a speech therapy evaluation. A 10/31/17 Nurse Practitioner note indicated the resident was not feeling well, didn't want to get out of bed, and had been refusing some medications. The note indicated authorization was given to give her Levoxyl with her other morning medications. Review of October 2017 and November 2017 Medication Administration Records (MARs) indicated the refusals of Levoxyl were due to wanting to take the medication with food and the medication remained scheduled for 5:45 a.m. daily. The MARs indicated her morning medications were offered and refused as late as 9:30 a.m., with refusal reasons			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	documented as wanting to take the medications with food. During an interview, on 11/14/17 at 1:38 p.m., Resident 23 indicated she was up daily for breakfast in the dining room by 7 a.m. During an interview, on 11/16/17 at 1:24 p.m., LPN 30 indicated Resident 23 went through phases of refusing her medications, but preferred to take them in the dining room with meals. She indicated she had asked the Social Services Director just that morning to add the preference to her plan of care. She indicated she would also take them with chocolate milk if it was in between meals. During an interview, on 11/16/17 at 1:33 p.m., the DON indicated the late times were due to that being the last time the medications were offered. She indicated she could not answer for the times the refusal reason indicated it was due to wanting to take them with food, but her care plan had been updated as of the time of the interview. During an interview, on 11/17/17 at 8:36 a.m., Resident 23 indicated she had previously been getting her medications with meals (for around the past year or			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	so), but then LPN 30 had told her they (the facility) couldn't do that anymore, so she didn't take the medications if they weren't given to her with food, as it made her feel sick. B. During an observation of Resident 8, on 11/15/17 at 8:30 a.m., she was observed to be missing several teeth, had teeth in poor condition, and her gums were observed to be reddened. She had an orange-colored smear near the right side of her mouth. She indicated her teeth did not cause her pain. Review of the clinical record began on 11/14/17 at 2:38 p.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), heart failure, and dysphagia (difficulty swallowing). A 6/21/17, significant change MDS assessment indicated she had obvious or likely cavities, or broken natural teeth. A 10/27/17, quarterly MDS assessment indicated she required the extensive assistance of one person for personal hygiene, including oral care. She had a current care plan problem of self-care deficit, requiring assistance with ADLs. Interventions included, but were not limited to, physical assistance of one			

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	person for oral/dental care of her natural teeth. Review of a 9/14/17 Dental Visit progress note indicated she had three teeth that were broken down and one with mobility, but she was not interested in cleanings or referral. The exam note indicated she had poor oral hygiene. During an interview, on 11/16/17 at 1:27 p.m., LPN 30 indicated she she did not know where Resident 8's toothbrush was kept. She indicated maybe CNA 31 had thrown in out, as the resident had a severe nose bleed the day before. During an interview, on 11/16/17 at 1:28 p.m., CNA 31 indicated she would assist Resident 8 sometimes to rinse her mouth or they used a foam mouth swab at times. After searching the resident's dresser drawers, she indicated "to be honest" the resident did not have a toothbrush available to her. During an interview, on 11/17/17 at 8:39 a.m., CNA 32 indicated Resident 8 used a toothbrush, indicating to a bag in the dresser drawer. Review of a 2006 policy titled "Oral Hygiene", provided by the Nurse Consultant on 11/17/17 at 11:22 a.m.,			

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	indicated the purpose of oral care was to cleanse the mouth and teeth, prevent infection and irritation, moisten the mouth, and to promote personal hygiene. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to follow Physician orders and complete related paperwork for condition monitoring for 1 of 1 resident records reviewed for dialysis(Resident 3). Findings include: A record review, on 11/17/17 8:50 a.m., indicated Resident 3 was admitted on 8/5/15. His diagnoses included, but were not limited to: chronic kidney disease, pseudobulbar affect, hypertension, depressive disorder, abnormality of gait and cognitive impairment. MDS (minimum data set) assessment, dated 9/5/17, indicated he had a BIMS (brief interview for mental status) score of thirteen, this score indicated he was cognitively intact. He had a PHQ9 (depression screening) score of two, this indicated he had no depression. The MDS also indicated he received	F 0309	F309- Resident 3 binder has been updated with complete related paperwork for condition monitoring and physician was notified regarding physician order on 11/20/17 by DON/Designee Residents receiving outside dialysis service could have the potential to be affected by this alleged deficient practice. Review of resident's paperwork and physician orders was completed by D.O.N/Designee on 11/20/17 with updates obtained as necessary. Nurse education on completing dialysis form prior to resident leaving the facility, verifying outside facility completed their portion of the form appropriately. Nurse to follow up with outside facility if not completed as well as nurse to complete post dialysis portion of the form when resident returns was conducted by D.O.N on 11/21/17 .	12/17/2017

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	hemodialysis treatments. Care plan focus, dated 6/28/17, indicated the resident was to receive hemodialysis treatments related to his end stage renal failure. Interventions included, but were not limited to: dialysis days Tuesday/Thursday/Saturday, give diet to the resident as ordered, obtain lab work as ordered, administer medications as ordered, monitor and notify medical doctor of signs and symptoms of fluid overload/shortness of breath/vomiting/hypertension/leg cramps/headache. Care plan focus, dated 9/8/17, indicated altered nutrition and hydration. Interventions included, but were not limited to: extra protein with meals, diet as ordered, offer a bedtime snack, monitor weight, notify Medical Doctor of significant weight change and use adaptive equipment as ordered. Physician order, dated 7/26/16, indicated the resident was to have pre and post dialysis assessments on dialysis days. Physician order, dated 2/14/17, indicated pre and post dialysis weights were to be obtained. A review of the last twenty-three Dialysis		D.O.N/Designee to perform audit on residents receiving dialysis 3x a week for 8 weeks, then monthly for 4 months to ensure physician orders are followed and completed paperwork is available for condition monitoring. Audits from DON/Designee will be brought to Quality Assurance Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of audits.	

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	Care Communication/ Coordination forms, on 11/17/17 at 9:12 a.m., indicated: three forms had no resident identifier, seven forms had no date, fourteen forms had no weights, ten forms had no post dialysis assessment and two forms had no pre dialysis assessment. During an interview with the DON, on 11/17/17 at 9:24 a.m., she indicated the form titled "Dialysis Care Communication/Coordination" was the only form the facility used to document the resident's dialysis information on. That form was to be filled out completely on each dialysis day. She indicated when the dialysis facility did not fill out their section of the form, the nurse on duty should have called the dialysis facility and obtained the missing information. She indicated there were two residents who received dialysis treatments at the facility. For the forms with no resident identifier filled out, she indicated there was no way of telling who's dialysis information it was. During an interview with LPN 23, on 11/17/17 at 9:50 a.m., she indicated before a resident left for dialysis the facility was to take the resident's vital signs, ensure they received a breakfast tray, administer ordered medications, fill out the dialysis form and ensure the			

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	dialysis book went with the resident to dialysis. While at the dialysis facility, they (dialysis facility) were to monitor the weights of the residents and fill out their section of the Dialysis Care Communication/Coordination form. She indicated if they didn't fill out the form there was nothing they could do about it because we (the facility) could not force them to fill it out. No further information was provided prior to exit. 3.1-37(a)			
F 0314 SS=G Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			

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	Based on observation, interview, and record review, the facility failed to provide services to prevent the occurance and to promote the healing of facility-aquired pressure ulcers for 1 of 1 residents reviewed for pressure ulcers developed after admission (Resident 18). This deficient practice resulted in the resident acquiring unstageable pressure ulcers to her feet. Findings include: On 11/14/17 at 1:25 p.m., Resident 18 was in her room, sitting in her recliner. She was wearing a pair of white athletic shoes on her feet, which were elevated on the recliner. She indicated she had recently bought the shoes, since the nurses told her the previous pair had caused sores on her feet. On 11/16/17 at 11:07 a.m., she was in her room, sitting in her recliner. She was wearing a pair of socks and slippers on her feet. On 11/17/17 at 8:15 a.m., she was in her room, sitting in her recliner. She was wearing a pair of white athletic shoes on her feet. Review of the clinical record began on 11/14/17 at 2:08 p.m. Diagnoses	F 0314	F314 Resident 18 Assessment completed on day of observation by Director of Nursing. New orders wre received and initiated. Care Plan reviewed and updated on 11/17/17 Skin inspections of residents were conducted on 12/8/17 by the D.O.N. Any resident noted with a skin integrity area have the potential to be affected by the alleged deficient practice. A review of residents with skin breakdown was conducted by the D.O.N on 11/21/17 to ensure interventions to prevent occurrence and to promote healing are in place with revisions implemented as needed. Nurse education on completing skin assessments appropriately, and calling NP at time of observation for new orders was conducted on 11/21/17. D.O.N/Designee to audit skin assessments for indication of new areas and new treatment orders in place weekly for 4 weeks, then every other week for 4 weeks, then monthly for 4 months to prevent occurrence and promote healing of skin breakdown. Audits from DON/Designee will be brought to Quality Assurance Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of	12/17/2017

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	included, but were not limited to, end stage renal disease, hypertension, repeated falls, and diabetes. A 10/12/17, quarterly, MDS assessment indicated she was cognitively intact, required supervision and set up with dressing and extensive assistance with personal hygiene. The assessment indicated she had two unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcers. She had a current careplan problem of a self-care deficit and needed physical assistance of one person with ADLs and dressing. She had a current careplan problem of a potential for impaired skin integrity. Interventions included, but were not limited to, lotion, cushion use, bath per schedule and evaluate skin weekly. She had a current careplan problem of an actual skin impairment to her left 5th digit. Interventions included, but were not limited to, identify causes and resolve when possible, non-skid socks, and weekly assessment.		audits.	

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	A 9/18/17 re-admission assessment indicated her skin was intact with the exception of a bruise to her arm. A 9/20/17 Wound Assessment indicated she required special equipment use of Skin Prep (a liquid film-forming barrier) for a bruise to her right foot 5th digit, which had been acquired in-house. The area measured 0.2 centimeters (cm) long x 0.2 cm wide with no depth. A 9/24/17 Progress Note indicated a callous to her left 5th digit with a black top measuring 1.2 cm long x 0.8 cm wide. The area was cleansed and skin prep was applied. A 10/1/17 Progress Note indicated open areas to her bilateral 5th digits, with the resident indicating her socks had stuck to her toes. A 10/1/17 Skin Inspection note and Progress Notes indicated she had pulled her socks off after they became stuck to her toes and the skin was missing with areas that were open/bleeding. Her left 5th digit was red and swollen, with a foul odor present. The notes indicated the information would be passed in report to have the wound nurse see her as soon as possible.			

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	There were no new treatment orders or assessments from 10/1/17 through 10/3/17. Wound Assessments, dated 10/3/17, indicated she had an unstageable 1.3 cm long x 1.2 cm wide wound, with a foul odor, to her left 5th digit and an unstageable 1.2 cm long x 1.2 cm wide wound to her right 5th digit. An order was received to treat the wounds with Medihoney (wound treatment). A 10/3/17 Progress Note indicated an order was received for Keflex (an antibiotic) 500 mg three times daily for 7 days for a wound infection. A 10/3/17 Nurse Practioner exam note indicated it appeared as if her new shoes were causing pressure to her toes, resulting in necrotic (dead) tissue bilaterally. An order was written for her to be taken to an orthopedic shoe store to be evaluated for therapeutic shoes. A 10/31/17 Social Services note indicated she had been fitted for diabetic shoes and they should be in by Thanksgiving. Wound assessments, dated 11/14/17, indicated the wound to her left 5th digit remained unstageable and measured 0.5			

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	cm long x 0.4 cm wide. The assessment indicated the wound to her right 5th digit had healed. An 11/15/17 Skin Inspection note indicated her skin was "clean, dry, and intact." An observation of Resident 18's feet, on 11/16/17 at 11:07 a.m., and accompanied by the DON, indicated the following: her left 5th digit had a dark scabbed area, approximately the diameter of a pencil, and her 3rd digit had an intact, darkened area, just above the cuticle, approximately the diameter of half of a pencil. Her right 5th digit had two scabbed areas, each approximately the diameter of a pencil. Wound Assessments, dated 11/16/17, indicated the newly identified pressure ulcers to her bilateral toes were unstageable. During an interview, on 11/16/17 at 2:21 p.m., the DON indicated she would have assessed the wounds initially on 10/3/17 during her first wound rounds (as she had not been employed the the facility prior to that time). During an interview, beginning on 11/17/17 at 9:46 a.m., the DON indicated			

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	the resident had received the order for an evaluation for specialty shoes on 10/3/17, but had not had it completed due to an issue with insurance, and had not been evaluated until 10/31/17 by another specialty shoe company. She indicated the resident had been encouraged to wear slippers instead of shoes, but she preferred shoes when she left the building for dialysis and other activities. She indicated she had not seen the resident's new shoes and the shoes had not been addressed in her care plan. Review of a policy, titled "Skin Integrity," dated August 2014, and provided by the Nurse Consultant on 11/16/17 at 3:11 p.m., indicated the following: "...Residents identified to be at risk for skin breakdown (pressure ulcers) will have a routine assessment and interdisciplinary (IDT) care plan process implemented to maintain and/or improve skin integrity. The objective is to create an on-going process to identify and actively manage risk and/or skin integrity issue(s), and to determine appropriate referrals or interventions to achieve positive clinical outcomes...." The policy indicated care plans were to be revised as appropriate and facility practices would be evaluated to determine changes needed to reduce, eliminate, and heal pressure ulcers.			

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	3.1-40(a)(1)			
F 0323 SS=E Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.			
	Based on observation and interview, the facility failed to ensure safe water	F 0323	F 323 Maintenance director lowered	12/17/2017

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	temperatures for 8 of 9 bathrooms on the 100 Hall (Rooms 103, 105, 106, 109, 110, 113, 114 and the shower room). Findings include: During initial tour on 11/14/17 at 11:19 a.m., all of the 100 Hall room's water temperatures were taken. The following temperatures above 120 degrees were obtained: Room 103 = 126 degrees Room 105 = 132 degrees Room 106 = 136 degrees Shower room = 124 degrees Room 109 = 129 degrees Room 113 = 125 degrees Room 114 = 120 degrees During an interview on 11/17/2017 at 11:14 a.m. with Resident 23 she indicated that the water was generally hot, but as long as you mixed it with cold water it was better. During the Environmental Tour with the Administrator, Housekeeping Supervisor and the Maintenance Director on 11/17/2017 at 11:08 a.m., the water temperatures were obtained by the Maintenance Director: Room 103 - 126 degrees		thermostat on water heater and adjusted cold water mixing valve on 11/17/17. Residents residing in the facility have the potential to be affected by the alleged deficient practice. Maintenance Director lowered thermostat on water heater and adjusted cold water mixing valve on 11/17/17. Elements and thermostat were replaced on 11/27/17 by Maintenance Director/Designee. Maintenance Director was re-educated regarding safe water temps by Executive Director on 12/8/17. Maintenance Director/Designee will audit of water temps at the nearest point-of-use (Room 101, 301) and the furthest point-of-use (Room 106, 306), respectively for each loop in use, and the public sink in the dining room, will be obtained 3 times a week for 8 weeks, then weekly for 8 weeks, then monthly for 2 months to ensure water temps are in a safe range. Results of rounds will be taken to Quality Assurance Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of audits.	

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	Room 105 - 137 degrees Shower room - 131 degrees On 11/17/2017 at 11:08 a.m., the Maintenance Director indicated that he did water temperatures twice a week. He indicated that the water temperatures always started off hot. He indicated that staff just knew that it was that way so they just let the water run for a while. He also indicated that it is the other staff's responsibility to let any new staff know about the water temperature. On 11/17/2017 at 2:42 p.m., The Director of Operations provided the water temperature logs for the weeks of 10/16/17, 10/23/17, 10/30/17 and 11/6/17, indicated water temperatures 120 degrees on 10/16/17 and 10/23/17. No further information was provided prior to ext from the facility. 3.1-19(r)(2)			
F 0329 SS=D Bldg. 00	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or			

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	(2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on observation, interview, and record review, the facility failed to ensure psychoactive medications were not increased without indication and failed to ensure gradual dose reductions (GDR) were completed timely.	F 0329	F329 Resident 19 melatonin has been discontinued and a GDR has been started 12/5/17 for the Xanax. Resident 2 discharged from facility on 11/23/17. Residents receiving psychoactive medications have the potential to be affected. New orders for	12/17/2017

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	Findings include: 1. On 11/15/17 at 10:01 a.m., Resident 19 was in the activity room with a group of residents. On 11/15/17 at 1:31 p.m., he was in his room, listening to the radio. On 11/16/17 at 8:17 a.m., he was in his room in his bed. The maintenance director brought his wheelchair in and indicated he had fixed the chair. On 11/16/17 at 9:41 a.m., he was in bed, with CNA 34 standing at the foot of the bed talking to him. On 11/17/17 at 8:15 a.m., he was in his room in his wheelchair, listening to music. Review of the clinical record began on 11/14/17 at 2:33 p.m. Diagnoses included, but were not limited to, dementia, pneumonia, CKD, insomnia, type 2 diabetes, chronic obstructive pulmonary disease (COPD), depression, bipolar disorder, and anxiety. He had current medication orders for, but not limited to, Buspar (antianxiety) 5 mg two tablets in the a.m., in the afternoon, and at bedtime, Melatonin 3 mg at		medications will be reviewed during monthly behavior management meetings to assure adequate indication for use and supporting documentation is present. Nursing staff education on proper procedure and protocol for obtaining new orders for psychoactive medication completed by the D.O.N on 11/21/17. Nurses' notes will be reviewed weekly for 6 months to ensure appropriate indications for dosage reduction or increases are addressed specific to each individual resident. Psychoactive medications will be monitored weekly for six months to ensure GDRs are completed timely. Audits from Social Services/Designee will be brought to Quality Assurance Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	11/17/2017

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	bedtime, trazodone (antidepressant) 100 mg at bedtime, and escitalopram (antidepressant) 20 mg once daily. A 10/25/17, annual, Minimum Data Set (MDS) assessment indicated he was cognitively intact, had a PHQ-9 (depression screening) score of zero, and had no behaviors, hallucinations, or delusions. He had a current careplan problem of depression, anxiety, and bipolar disorder with occasional health related complaints, and not sleeping well. Interventions included, but were not limited to, medications, psychiatric consult, monitor residents, and provide activities. Review of Progress Notes indicated the following: A 9/21/17 physician note indicated he complained of difficulty sleeping and an order was written to increase his trazodone from 50 mg at bedtime to 100 mg at bedtime. A 10/3/17 psychologist note indicated he had complained of not sleeping well, but nursing was not aware of it. A 10/16/17 note indicated a new order			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	for Melatonin 3 mg at bedtime for sleep. There was no other mention as to why the medication order was written. A 10/20/17 Social Services note indicated he was up daily, ate his meals in the dining room, and attended activities of interest. An 11/7/17 psychologist note indicated he complained of sleep problems due to excessive phlegm, but was doing well. During an interview, on 11/17/17 at 9:26 a.m., CNA 35 indicated Resident 19 would lay down after lunch until supper, except for Tuesday bingo. During an interview, on 11/17/17 at 11:09 a.m., the SSD indicated the resident's insomnia had not been monitored. She indicated she was not aware of his being on Melatonin for sleep. On 11/17/17 at 1:33 p.m., the SSD indicated the facility medical director increased the trazodone for difficulty sleeping and the MDS assessment indicated having trouble sleeping in August. She indicated the psychiatric nurse practitioner (NP) addressed the trazodone in January when it was due for GDR, and it was not done since three			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	other medications (Buspar, trazodone, and Xanax) were due at the same time, so the facility chose to increase the Lexapro in an effort to decrease his night time Xanax. She indicated the he was supposed to be seen by the facility's new psychiatric nurse practitioner, but he did not get seen. She indicated again she was not aware of why the Melatonin was started and the facility did not ask for the trazodone to be increased. 2. A record review, on 11/15/17 at 1:57 p.m., indicated Resident 2 was admitted on 5/10/13. His diagnoses included, but were not limited to: Alzheimer's disease, epilepsy, dementia without behavioral disturbances, depression, Diabetes Mellitus II, repeated falls and cognitive communication deficit. MDS (Minimum Data Set) assessment, dated 9/19/17, indicated he had a BIMS (brief interview for mental status) score of four, indicating severe cognitive impairment. He had a PHQ9 (depression screening) of zero, indicating he was unable to be screened for depression. A care plan focus, dated 5/3/15, indicated depression. Interventions included, but were not limited to: administer medications as ordered, arrange for psychological consultations, encourage family visits/clergy visits and			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	monitor/document/report any signs/symptoms of depression. A physician order, dated 3/8/16, indicated the resident was to receive Paroxetine (anti-depressant) 10 mg daily for the diagnosis of depression. A physician order, dated 10/19/16, indicated the resident's dose of Paroxetine was to be increased to 20 mg daily for the diagnosis of depression. A Nurse Practitioner progress note, dated 1/24/17, indicated a request by the ADON (assistant director of nursing) to re-evaluate mood, effectiveness of psychotropic medication and address pharmacy recommendation for Paxil (Paroxetine) GDR (gradual dose reduction). The GDR was clinically contraindicated as the resident intermittently was sexually inappropriate with the staff and his wife reported he was mean/rude to her at times. The resident's appetite was fair and he slept ok. A Nurse Practitioner progress note, dated 7/26/17, indicated a request by the ADON to re-evaluate mood, effectiveness of psychotropic medications and address a pharmacy recommendation			

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	that Paxil (Paroxetine) was due for GDR. It was clinically contraindicated as he had been ill with pneumonia and on antibiotics. His appetite was fair and slept ok. Behavior management team review note, dated 7/25/17, indicated for the previous thirty days before this meeting the resident had two behaviors of yelling out, two behaviors of rejecting care and one behavior of being sexually inappropriate. Behavior management team review note, dated 8/25/17, indicated for the previous thirty days before this meeting the resident had eleven behaviors of yelling out, resisting care, sexual behaviors and/or threatening others. Behavior management team review note, dated 9/26/17, indicated for the previous thirty days before this meeting the resident had one episode of hitting and one episode of rejecting care. Behavior management team review note, dated 10/21/17, indicated for the previous thirty days before this meeting the resident had two episodes of being sexually inappropriate, three episodes of yelling out and two threatening behaviors.			

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	Review of mood and behavior charting for the resident, from 1/1/17 through 11/16/17, indicated no behaviors of depression, crying, self isolation or sad facial expressions. During an interview with the Social Service Director, on 11/17/17 at 10:01 a.m., she indicated behavior meeting were held once a month with pharmacy reviews of medications and recommendations for GDR's (gradual drug reduction). She indicated for anti-depressants, GDR's were to be attempted twice during the first year unless there were extenuating circumstances. She indicated she had no further documentation of signs/symptoms of increased depression to support an increase in the Paroxetine. She indicated she had no further behavior documentation to provide. During an interview with CNA 24, on 11/17/17 at 10:06 a.m., she indicated the resident had many behaviors but he had never appeared to be depressed to her. She indicated he did not have crying episodes, depressed statements or sad facial expressions. During an observation, on 11/14/17 at 9:53 a.m., the resident was up in his wheelchair. He was smiling and pleasant			

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	during conversation. No signs /symptoms of depression noted. During an observation, on 11/15/17 at 8:18 a.m., the resident was in bed eating breakfast. He was smiling an pleasant. No signs/symptoms of depression noted. On 11/17/17 at 2:44 p.m., the DON provided a policy titled "Psychoactive Medication Management". This policy was dated August 2014. The policy indicated "...11. Residents receiving antipsychotic, anti-anxiety, anti-depressant and/or sedative/hypnotic mediations should be evaluated no less often than Quarterly for on-going clinical appropriateness and consideration of a gradual dose reduction attempt"..."antipsychotics, mood stabilizers, antidepressants and anxiolytics:GDR attempt twice in the first year....". 3.1-48(a)(4)			
F 0332 SS=D Bldg. 00	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure	F 0332	F332 Resident 19 - 1:1 education by D.O.N	12/17/2017

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	medications were administered as ordered for 3 of 31 medications observed during medication pass, resulting in a medication error rate of 9.7%. Findings include: During a medication administration observation, beginning on 11/15/17 at 9:48 a.m., RN 33 administered 100 units of Novolin 70/30 to Resident 19, in his right upper arm, as she sat in his room in his wheelchair. She then administered his morning medications including, but not limited to, one tablet of Buspar (antianxiety) 5 mg. Review of the clinical record began on 11/14/17 at 2:33 p.m. Diagnoses included but were not limited to, dementia, pneumonia, chronic kidney disease, insomnia, type 2 diabetes, COPD, depression, bipolar disorder, and anxiety. He had current medication orders for, but not limited to, Novolin 70/30 100 units in the morning (scheduled for 7 a.m., to correlate with breakfast) and for Buspar 5 mg give two tablets (equal to 10 mg) twice daily in the morning and at bedtime. During a medication administration		with nurse 33 on Insulin Administration and administering medications as ordered by the physician was conducted by D.O.N on 12/7/17. Nurses were re-educated on insulin and medication administration on 11/21/17. Resident 40- D.O.N verified orders with nurse 30 on flushing picc with normal saline prior to medication administration on 11/17/17. Residents could have the potential to be affected by this alleged deficient practice. Re-education was conducted by D.O.N with nurses on 11/21/17 to ensure medications were administered as ordered. Nurse re-education on administration of medication conducted by D.O.N on 11/21/17. D.O.N/Designee to perform audit on 5 residents medication administration weekly for 4 weeks, then 3 residents medication administration every other week for 4 weeks, then 3 resident medication administration monthly for 4 months to ensure medications are administered as ordered. Negative findings will be corrected immediately upon identification. Audits from DON/Designee will be brought to Quality Assurance Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of audits.	

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	observation, beginning on 11/15/17 at 1:05 p.m.. LPN 30 began preparing to administer Ceftin (antibiotic) 2 grams in 100 mL of IV fluid to Resident 40 through his PICC line (an intravenous (IV) central line used for long term therapy). After cleaning, she attached a 10 milliliter (mL) syringe containing normal saline to the PICC line port, pulled the plunger back to verify blood flow, and flushed the line with 5 mL of the saline. She removed the syringe, containing approximately 5 mL of saline tinted with blood, and placed it on the bed, inside a piece of plastic wrapping. She then connected the tubing from the IV bag to the PICC line and began administering the medication per an IV pump. Review of the clinical record began on 11/15/17 at 1:30 p.m. Diagnoses included, but were not limited to, bacterial intestinal infection and osteomyelitis. He had current medication orders for, but not limited to, Sodium Chloride (normal saline) 10 mL intravenously prior to medication administration. On 11/16/17 at 3:03 p.m., LPN 30 indicated she did not flush prior to administering the IV medication, she was			

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	only checking for placement. She indicated "you don't flush prior to med administration." She indicated the orders were to use 5 mL of saline prior to medications and then 10 mL was used when locking the system with heparin. Review of a policy, titled "Central Vascular Access Device (CVAD) Flushing and Locking," revised May 1, 2016, and provided by the Nurse Consultant on 11/17/17 at 10:44 a.m., indicated flushing is performed to ensure and maintain catheter patency. 3.1-25(b)(9)			
F 0334 SS=E Bldg. 00	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:			

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	(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to ensure pneumococcal vaccinations were completed for 4 of 5 residents (18, 4, 21, 24) reviewed for influenza/pneumococcal immunizations. Findings include: 1. During a record review for Resident 18, on 11/15/17 at 10:08 a.m., the clinical record review lacked indication of the pneumococcal vaccine. 2. During a record review for Resident 21, on 11/15/17 at 10:09 a.m., the clinical record review lacked indication of the pneumococcal vaccine. 3. During a record review for Resident 4, on 11/15/17 at 10:09 a.m., it indicated the resident had a historical record that she had received the first dose of the pneumococcal vaccine on 1/1/08. There was no indication she received any additional doses.	F 0334	F334 Resident 18, 21, 4, 21, 24 consents being received for pneumococcal vaccinations, vaccinations ordered and vaccine to be administered to consenting residents. Residents could have the potential to be affected by this alleged deficient practice. An audit of resident pneumococcal vaccinations, versus consents was conducted by D.O.N on 12/8/17 with findings corrected as needed to ensure pneumococcal vaccinations were given. Nurse re-education on administration of vaccinations after consent received was conducted by D.O.N on 11/21/17. D.O.N/Designee to perform audit on residents that have received, or declined, pneumococcal vaccination. D.O.N/Designee to audit new admits no later than 72 hours after admit to ensure consent received or declined and vaccination administered as applicable. Audits from DON/Designee will be brought to Quality Assurance	12/17/2017

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	An interview with the DON, on 11/15/17 at 10:58 a.m., indicated there were no additional records the facility had addressing further doses for the residents and it was unknown to the facility if the residents were current on her pneumococcal vaccine. 4. During a record review for Resident 24, on 11/15/17 at 10:10 a.m., it indicated on 4/11/17 the resident was not eligible for the pneumococcal vaccine. An interview with the DON, on 11/15/17 at 11:58 a.m., indicated she did not know why the resident was not eligible for the vaccine. She indicated there were no further screening records as to why he was not eligible. On 11/15/17 at 10:57 a.m., a policy was provided by the DON titled "Administering Pneumococcal Vaccine to Adults", dated 2012. This policy indicated " ...vaccinating all adults who meet the criteria..." and "...Identify adults in need of vaccination with pneumococcal vaccine..." 3.1-13(a)		Performance Improvement Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of audits.	
F 0431 SS=D Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS			

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	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under			

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	155444	A. BUILDING 00 B. WING	11/17/2017

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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
	proper temperature controls, and permit only authorized personnel to have access to the keys. (2) 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. Based on observation and interview, the facility failed to ensure 1 of 1 treatment cart remained locked and secured when not in use. Findings include: During the initial tour of the facility, on 11/14/17 at 9:14 am., an unlocked treatment cart was noted on the 100 Hall. Items inside included, but were not limited to: intravenous access start kits (including needles), nystop (anti-fungal) powder and cream, aloe vesta gel, skin staple remover kits, calazime cream (without a resident identifier), lidocaine cream, anti fungal cream, open foam dressings and a 16 ounce bottle of wound cleanser. During an interview with LPN 26, on 11/14/17 at 9:17 a.m., he indicated the treatment cart was to be kept locked	F 0431	F431 LPN 26 left treatment cart unlocked in common area, LPN 26 re-educated by D.O.N on 12/7/17 to keep treatment cart and drug storage area locked. Residents residing in the facility could have the potential to be affected by this alleged deficient practice. Nurse education on Medication carts and treatment carts being locked at all times while left unattended was conducted on 11/21/17 by the D.O.N D.O.N/ Designee to audit that Medication carts and Treatment carts to ensure they are locked when left unattended 5x/week for 4 weeks, then 3 times per week for 4 weeks, then monthly for 4 months to ensure medication storage carts are kept secure. Audits from DON/Designee will be brought to Quality Assurance Performance Improvement	12/17/2017

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	155444	A. BUILDING 00 B. WING	11/17/2017

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	when not in use. After the interview was completed, he walked away from the treatment cart leaving it unlocked. During an observation, on 11/14/17 at 9:24 a.m., a CNA and Resident 20 passed the unlocked treatment cart. On 11/17/17 at 11:22 a.m., the Corporate Consultant provided a policy title "Storage and Expiration of Medications, Biologics, Syringes and Needles" dated 12/1/07. This policy indicated, "...3.3 Facility should ensure that all medications and biological's, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors....". 3.1-25(m)		Committee monthly for 6 months for further review or recommendations. Compliance will be determined based on results of audits.	
F 0441 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a			

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	contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident			

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	contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to maintain proper infection control precautions related to the handling of a urinary drainage system for 1 of 1 resident observed with a catheter. (Resident 22) Findings include: On 11/15/17 at 1:35 p.m., Resident 22 was observed in bed with his urinary catheter drainage tubing hanging on the floor and the drainage bag was lying on the floor. On 11/15/17 at 2:45 p.m., Resident 22 was observed with his urinary catheter drainage bag lying on floor and the tubing was seen coming out of the residents pant leg and was lying on the floor below the foot pedals of the wheel chair as the resident was sitting in the	F 0441	F441 Resident #22's urinary catheter clip replaced by D.O.N on 11/17/17 so catheter was no longer touching the floor. Residents with urinary catheters have the potential to be affected by this alleged deficient practice. No other residents in facility with catheters. Staff education on appropriate placement of urinary catheters was conducted by the D.O.N on 11/21/17 to ensure proper infection control precautions. D.O.N/Designee to audit residents with current urinary catheters and check placement of tubing 5 times a week for 4 weeks, 3 times a week for 4 weeks and monthly for 4 months to ensure proper infection control practices are maintained related to urinary drainage systems. Audits from DON/Designee will be brought to Quality Assurance Performance Improvement Committee monthly for 6 months	12/17/2017

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	dining room listening to the music. On 11/16/2017 at 9:41 a.m., Resident 22 was observed sitting by the nurse's station with his urinary catheter drainage bag and tubing lying on floor. On 11/16/2017 at 10:17 a.m., Resident 22 was observed sitting by the nurse's station with his urinary catheter drainage bag and tubing lying on floor. On 11/16/2017 at 1:40 p.m. Resident 22 was observed in bed with his urinary catheter drainage tubing hanging on the floor and the drainage bag was lying on the floor. On 11/17/2017 at 8:30 a.m., Resident 22 was in his room watching TV with the urinary catheter tubing lying on floor. On 11/17/2017 8:45 a.m., Resident 22 was being pushed to therapy by a therapist with the urinary catheter tubing dragging on floor from his room to the therapy room. On 11/17/2017 at 9:31 a.m., Resident 22 was in his room watching TV with the urinary catheter tubing lying on floor. Resident 22's clinical record was reviewed on 11/15/2017 at 2:13 p.m. The		for further review or recommendations. Compliance will be determined based on results of audits.	

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	resident's diagnosis included, but are not limited to Urinary Tract Infections, site not specific and Type 2 Diabetes Mellitus and Obstructive and Reflux Uropathy. He had current Physician orders for, but not limited to, the following: Lasix 40 mg (anti-edema) twice daily for retention related to acute systolic (congestive) heart failure, repeat UA & C&S (urine analysis with culture and sensitivity), Foley Catheter to gravity drainage every shift for urinary retention and an appointment with Dr. Brinkman (urologist) on 12/6/17. An annual, 10/13/17, Minimum Data Set assessment (MDS) indicated he was mildly cognitively impaired. Care plan initiated 10/13/17 and last reviewed 11/07/17 indicated, "High Risk for Urinary Tract Infection and complications due to: Indwelling Catheter placed 10/13/17 due to urinary retention, prostate cancer with possible mass-to remain in place until urology appointment. ... Goal: ...Resident will not experience signs and symptoms of urinary tract infection each week through the review date ... Interventions ... Ensure catheter tubing and drainage bag are properly positioned to prevent urinary back flow or contamination ... date			

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	initiated 10/13/17 ...revision date 10/19/17. " On 11/16/2017 at 10:29 a.m., during an interview with CNA 41 indicated that when a resident that had a urinary catheter the resident should never have the drainage bag or tubing touching the floor. On 11/16/2017 at 10:31 a.m., during an interview with CNA 41 she indicated that his urinary catheter drainage bag and tubing were lying on the floor. On 11/16/2017 at 11:00 a.m., the Director of Nursing (DON) indicated that according to policy a resident with a indwelling bladder catheter should not have either the drainage bag or the tubing on the floor. A current facility policy, not dated, titled "Procedure 260 Catheter insertion and removal" was provided by the Regional Clinical Nurse Consultant on 11/16/17 at 10:44 a.m., she indicated the policy was the one currently used by the facility. The policy indicated, "...Procedure ... 11. Secure urinary drainage bag below the level of the bladder and keep off the floor at all times. Coil extra tubing and secure."			

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	3.1-18(j)			