STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DRIVE DYER, IN46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 29, 30,& 31, 2011 September 1, 2, & 6, 2011 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Survey team: Janet Adams, RN, TC Lara Richards, RN Heather Tuttle, RN Kathleen Vargas, RN Census bed type: SNF/NF: 131 Total: 131 Census payor type: Medicare: 29 Medicaid: 80 Other: 22 Total: 131 Stage 2 Sample: 53 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the 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 corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to	

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

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	Quality review 9/09/11 by Suzanne Williams, RN		participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility.	

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F0156 SS=E	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. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently 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. Based on record review and interview, the facility failed to ensure Medicare stop letters were provided to residents and/or their responsible party for discharge from Skilled services for 3 of 3 residents reviewed for receiving liability notices after the discontinuation of therapy services. (Residents #21, #60, & #143) Findings include: 1. The closed record for Resident #60 was reviewed on 9/2/11 at 8:38 a.m. The resident was admitted to the facility from the hospital on 7/16/11. The resident was discharged to her home on 7/29/11. The 7/16/11 admission Physician orders were reviewed. There was an order written for Physical Therapy, Occupational Therapy, and Speech Therapy services to evaluate and treat the resident.	F0156	**F – 156** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R60, R143 & R21 were not harmed by the deficient practice. Medicare stop letters were issued for the above residents**. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **All residents discharged from Medicare in the last 30 days**	10/06/2011

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	Review of the 7/28/11 Therapy Discharge Summary indicated the resident received skilled therapy services from 7/18/11 through 7/28/11. The summary indicated the resident was discharged to her home on 7/29/11. Review of the Occupational Therapy Discharge Summary indicated the resident received skilled therapy services from 7/18/11 through 7/28/11. The summary indicated the reason the resident was discharged as the resident had met her highest potential. Review of the Speech Pathology Discharge Summary indicated the resident received skilled therapy services from 7/18/11 through 7/28/11. The summary indicated the resident was discharged home with her family on 7/29/11. When interviewed on 9/6/11 at 11:50 a.m., the facility Administrator indicated the resident and or the resident's responsible party should have been given written information related to discontinuation of the Medicare Skilled Services when they were discharged from therapy services.		**will be reviewed and Medicare stop letters will be issued where indicated.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Case Manager has been re-educated on processing Medicare stop letters.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool related to monitoring compliance with Medicare stop letters being issued in a timely matter will be completed weekly by ED or designee. This tool will continue to be completed weekly for a month, then monthly for a quarter, and then quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance has been achieved.** POC date: 10/6/11	

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	2. The closed record for Resident #143 was reviewed on 9/2/11 at 9:03 a.m. The resident was admitted to the facility on 2/24/11. The resident was sent to the hospital on 3/21/11 and was readmitted to the facility on 3/28/11. The resident was discharged to her home on 5/4/11. The 3/28/11 admission Physician Orders indicated there were orders for the resident to receive Physical Therapy and Occupational Therapy services. Review of the 5/6/11 Physical Therapy Discharge Summary indicated the resident received services from 3/29/11 through 5/3/11. The summary indicated the resident was being discharged. Review of the 5/3/11 Occupational Therapy Discharge Summary indicated the resident received services from 3/29/11 through 5/3/11. The summary also indicated the resident had met her highest potential and was being discharged to her home. When interviewed on 9/6/11 at 11:50 a.m., the facility Administrator			

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	indicated the resident and or the resident's responsible party should have been given written information related to discontinuation of the Medicare Skilled Services when they were discharged from therapy services. 3. The closed record for Resident #21 was reviewed on 9/2/11 at 9:51 a.m. The resident was admitted to the facility on 7/12/11. The resident was admitted from the hospital. The 7/12/11 admission Physician orders indicted there were orders for the resident to receive Physical and Occupational Therapy treatments. Review of the 8/1/11 Physical Therapy Discharge Summary indicated the resident received services from 7/13/11 through 8/1/11. Review of the 8/1/11 Occupational Therapy Discharge Summary indicated the resident was discharged from therapy services on 8/1/11. When interviewed on 9/6/11 at 11:50 a.m., the facility Administrator indicated the resident and or the resident's responsible party should have been given written information related to discontinuation of the			

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	Medicare Skilled Services when they were discharged from therapy services. 3.1-4(f)(4)			
F0157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the	F0157	**F – 157** It is the practice of this facility to	10/06/2011

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	physician and the interested family member were notified of a significant weight loss for 2 of 3 residents reviewed for nutrition of the 11 residents who met the criteria for nutrition and 1 of 1 resident who met the criteria for notification of changes. (Residents #94, #101, and #121) Findings include: 1. The record for Resident #94 was reviewed on 8/30/11 at 3:28 p.m. The resident had diagnoses that included, but were not limited to, hypothyroidism, malnutrition, and hypertension. An entry, dated 8/20/11, in the "Resident Progress Notes" was reviewed. The entry was written by the Registered Dietician. The entry indicated, "Annual Nutritional Review. Current wt [weight] is 102.5# at the beginning of the month overall stable since April. Goal: wt stability/wt gain to normal BMI range. BMI is 16.9 underwt status ... rec [recommend]: encourage oral intake, add 2 cal HN [a nutritional supplement] 2 oz [ounces] po [by mouth] bid [twice daily] to facilitate wt gain. Will continue to monitor wt/status intakes. Follow up as needed."		ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Physician notification was completed for R121; R94; R101 related to weight loss concerns and dietician recommendations.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A review of all resident's exhibiting weight loss or requiring implementation of a dietician recommendation within the last 30 days will be completed to validate physician notification. Identified issues will be immediately addressed.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Unit Managers and licensed nursing staff will be re-educated related to physician notification for**	

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	The Nursing Progress Notes, dated 8/20/11 to 8/30/11, were reviewed. The physician was not notified of the Registered Dietician's recommendation to provide the nutritional supplement. Interview with the East Unit Manager on 8/31/11 at 3:10 p.m. indicated the nutritional supplement was not ordered by the physician. She indicated the physician was not notified of the Registered Dietitian's recommendation. 2. The record for Resident #101 was reviewed on 8/31/11 at 9:12 a.m. The resident had diagnoses that included, but were not limited to, diabetes, multiple sclerosis, and hypertension. The form titled "Individual Resident Weight History" was reviewed. The resident's weights were as follows: 6/9/11 170.2 pounds 7/24/11 175 pounds 7/31/11 178.2 pounds 8/1/11 178.2 pounds 8/15/11 162.5 pounds reweigh date 8/18/11 165 pounds 8/21/11 162 pounds Review of the Nursing Progress Notes		**weight loss and dietician/nutritional interventions.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool related to physician and family notification will be completed weekly by the Dietitian or designee. This tool will continue to be completed weekly for a month, monthly for a quarter, and then quarterly there after with results being forwarded to the PI committee for further review until 100% compliance is achieved.** POC date: 10/6/11	

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	dated 8/15/11 through 8/30/11 indicated the physician and the family were not notified of the resident's weight loss that was noted on 8/15/11 and 8/18/11. The Nurse Practitioner progress notes dated 8/17/11 and 8/29/11 were reviewed. The Nurse Practitioner did not indicate the resident had a recent weight loss. Interview with the East Unit Manager on 8/31/11 at 1:30 p.m., indicated the physician and the family were not notified of the residents weight loss. Interview with the Nurse Consultant on 8/31/11 at 1:39 p.m., indicated the physician and family were to be notified when a significant weight loss was noted. Interview with the Registered Dietician on 9/6/11 at 8:45 a.m., indicated the resident's weight loss from 8/1/11 to 8/18/11, was a significant weight loss of 7.4%. She also indicated the physician and family should have been notified of the significant weight loss. 3. The record for Resident #121 was reviewed on 8/30/11 at 3:08 p.m. The			

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	resident had diagnoses that included, but were not limited to, hypertension, anemia, and chronic kidney disease. The form titled "Individual Resident Weight History" was reviewed. The resident's weights were as follows: 5/3/11 126.5 pounds 6/1/11 119.9 pounds The Dietary Progress Notes were reviewed. A 6/22/11 entry indicated "Resident reviewed for significant weight loss. June weight 119.9 down 6.6 # /mo (5.2%) ..." The Nursing Progress Notes dated 6/1/11 through 6/30/11 were reviewed. There was no documentation of physician and family notification of the weight loss. Interview with the East Unit Manager on 9/1/11 at 9:10 a.m. indicated the physician and the family were not notified of the resident's significant weight loss. 3.1-5(a)(3)			
F0165 SS=D	A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.			

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	Based on record review and interview, the facility failed to ensure the complaint/grievance process was implemented when a resident had a complaint related to resident care issues for 1 of 13 residents who were interviewed. (Resident #134) Findings include: Interview with Resident #134 on 8/29/11 at 3:39 p.m., indicated about a week ago, she had to wait a long time to get changed after being incontinent of urine and when she asked CNA #7 to change her, the CNA told her that she wasn't her aide. The record for Resident #134 was reviewed on 9/1/11 at 8:48 a.m. The resident's diagnoses included, but was not limited to, depression. A Social Service Progress Note dated 8/26/11 (no time) indicated the following, "Resident's CNA came to writer and expressed her concern because the resident was upset with her. Explained that she was assisting in Main Dining Room when this resident asked for help and explained briefly to her she was in the Main Dining Room and couldn't leave the residents. CNA did return to help resident when possible. When writer	F0165	**F – 165** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R134's grievance was addressed and resolved.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **All interviewable residents will be asked if they had any unresolved grievances. No other issues were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All staff will be re-educated on grievance process, reporting and necessary follow up.** To ensure the deficient practice does not recur, the monitoring	10/06/2011

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	checked on resident related to this incident, resident stated that the CNA was "mad at her." Inquired as to reason and resident said she (CNA) wouldn't help her. Writer assured resident that CNA was not mad at her, just couldn't assist her immediately. Resident has history of thinking staff, or ancillary workers are upset with her if they do not help her immediately and ask her to wait. Resident sees (name of a counseling group) for counseling, however, will be seen by psychiatrist at next visit. Anxiety, fear, and complaints have increased over past month. Will continue to observe and assist resident as needed." A Social Service Progress Note dated 8/29/11 (no time) indicated, "Spoke with resident's daughter about a psychiatric appointment consent. Daughter made aware of recent increase in accusations and anxieties. Confirmed upcoming Care Plan meeting." There was no further documentation in the Social Service notes related to the resident's behaviors and staff treatment. On 9/2/11 at 1:31 p.m., interview with the West Social Service Director, indicated she was approached by		system established is: **A Performance Improvement tool related to follow through on resident/family grievances will be completed weekly by the Angels. This tool will continue to be completed weekly for a month, monthly for a quarter, and then quarterly there after with results being forwarded to the PI committee for further review until 100% compliance is achieved.** **Staff will inquire during weekly angel care rounds about any resident care issues and complete grievance process as necessary.** POC date: 10/6/11	

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	155218	A. BUILDING 00 B. WING	09/06/2011

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	CNA #7 last Friday. CNA #7 indicated the resident was upset with her because she would not change her right away. The CNA indicated to Social Service she was needed down in the Main Dining Room due to no staff in there. Interview with the West Unit Manager at this time, indicated when she went and talked to the resident, the resident indicated she had to wait to be changed. The Unit Manager indicated that she had instructed staff not to leave the Main Dining Room unattended. CNA #7 indicated when she got to the Main Dining Room, she told another CNA to go and change the resident. When the Unit Manager followed up with the resident, the resident indicated that she had been changed and everything was ok. She indicated she followed up with the resident on Monday 8/29 and the resident indicated everything was ok. The Unit Manager further indicated this was not documented in the resident's record. She indicated she told nursing to do 72 hour behavior charting. Interview with the Administrator at this time, indicated a concern/grievance form should have been completed and that would have captured the investigation and follow up documentation.			

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	The facility Complaints/Grievance policy was reviewed on 8/31/11 at 2:45 p.m. The policy was provided by the Administrator and identified as current. The policy indicated the following: 1. Acknowledge and document the complaint/grievance. 2. Forward the form to Executive Director/Designee. 3. Record the date, resident/family name, and issues or concern on the center complaints/grievance log. 4. Assign the appropriate Department Head to investigate. 5. Investigate to validate the complaint/grievance. 6. Notify resident and/or family/responsible party of progress within three (3) days of initial complaint/grievance. 7. Determine a resolution. 3.1-7(a)(1)			
F0166 SS=D	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 record review and interview, the facility failed to ensure prompt efforts were made to resolve a grievance related to missing personal items for 1 of 3 residents reviewed of	F0166	**F – 166** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the	10/06/2011

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	the 6 residents who met the criteria for personal property. (Resident #40) Findings include: Interview with Resident #40 on 8/30/11 at 9:00 a.m., indicated she had a lock box taken from her room a few months ago. The resident indicated the lock box contained money. She further indicated she told staff but the box was still missing. The record for Resident #40 was reviewed on 8/30/11 at 3:37 p.m. There was no documentation completed related to missing items. Interview with the West Unit Social Service Director on 9/1/11 at 11:39 a.m., indicated she found a copy of the grievance in her office and gave it to the front office. She indicated at the time the grievance was filed, the resident refused a new lock box. She indicated the money wasn't replaced due to she didn't have the authority to do that. She indicated the administrator was now aware and the money would be replaced. The Complaint and Grievance Form dated 5/11/11 was reviewed on 9/1/11 at 11:45 a.m. The form indicated the resident was missing a gray lock box		following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R40's grievance was addressed and resolved.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Grievances for the past 30 days will be reviewed to ensure timely follow up and resolution of identified concerns. No other issues were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All staff will be re-educated on grievance process, reporting and necessary follow up.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool related to follow through on resident/family grievances**	

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	with cash inside $20. Report taken by an LPN. Referred to Social Service documentation indicated the resident refused the lock box. The bottom of the form was not completed by the Executive Director. There was no documentation of an investigation and/or resolution. On 9/1/11 at 11:45 a.m., interview with the Administrator indicated she was not aware of the grievance filed by the resident back in May. She indicated Social Service staff did not inform her of the grievance. She further indicated an investigation should have been completed related to what happened to the resident's lock box. She indicated she would go down and talk to the resident and offer to replace the box. The facility Complaints/Grievance policy was reviewed on 8/31/11 at 2:45 p.m. The policy was provided by the Administrator and identified as current. The policy indicated the following: 1. Acknowledge and document the complaint/grievance. 2. Forward the form to Executive Director/Designee. 3. Record the date, resident/family name, and issues or concern on the		**will be completed weekly by the ED or designee. This tool will continue to be completed weekly for a month, monthly for a quarter, and then quarterly there after with results being forwarded to the PI committee for further review until 100% compliance is achieved.** **Staff will inquire during weekly angel care rounds about any resident care issues and complete grievance process as necessary.** POC date: 10/6/11	

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	center complaints/grievance log. 4. Assign the appropriate Department Head to investigate. 5. Investigate to validate the complaint/grievance. 6. Notify resident and/or family/responsible party of progress within three (3) days of initial complaint/grievance. 7. Determine a resolution. 3.1-7(a)(2)			
F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the residents' environment was clean and in good repair, related to marred and paint chipped walls, dusty ceiling vents, marred floor registers, missing wall tile, urine odors, marred furniture, and closet doors for 3 of 3 units. This had the potential to affect 131 of 131 residents who resided in the facility. (The West, East and South Units) Findings include: 1. The following was observed during	F0253	**F – 253** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Rm. 120 was cleaned and the closet doors were cleaned; The walls in Rm. 125 were painted, the walls in Rm. 104 were fixed and painted; the tiles were fixed in Rm. 136; the walls and vent were painted in Rm. 116; the door frame, door**	10/06/2011

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	the environmental tour on 9/6/11 at 10:45 a.m., on the West Unit: A. There was a stale urine odor in room 120. The closet doors were marred and the edges by the wall and of the closet door were paint chipped and marred. At that time, the Housekeeping Supervisor opened the closet the doors. There was a strong urine odor inside the closet. The Housekeeping Supervisor indicated the resident places her dirty clothes inside the closet and buries them. She further indicated the 2:00 p.m. -10:00 p.m. CNA was responsible for checking this daily. There were two residents who resided in this room. B. The wall next to closet door was scratched and marred. The walls in bathroom were also scratched and marred in room 125. There were two residents who resided in this room. C. In room 104 the walls next to the television stand were marred. There was a gouged area of plaster about one inch in diameter. Inside the bathroom door the walls were marred with black streaks. There were two residents who resided in this room. D. In room 136 there was "v" shaped section of linoleum tile missing by the		**and wall in Rm. 109 were painted; the bathroom door, door frame and wall in Rm. 111 were painted and the dresser was replaced; the floor register and bathroom door in Rm. 133 were painted, the floor tile in Rm. 110 was replaced; the porcelain on inside of the toilet was replaced and the wall was painted in Rm. 137; the ceiling vent in Rm. 14 was cleaned; the IV pole in Rm. 9 was cleaned; the ceiling vent in the East Unit Men's shower room was cleaned and the bulb above the sink was replaced and the shower head was replaced, the ceiling vent and toilet bowl was cleaned in the East Unit Women's Shower Room. The building has been approved for a major renovation which will include the East Shower Room.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **All rooms will be audited for maintenance concerns and any areas found will be fixed. The majority of the building has been approved for a major renovation that will be completed by the end of calendar year 2011.** The measures put into place and systemic change made to ensure the deficient practice does not	

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	base of the heat register. The tile was also loose and peeling. There were two residents who resided in this room. E. In room 116 the wall in the bathroom was marred with chipped paint. The paint on the corner of the register vent next to the window was scraped. There were two residents who resided in this room. F. In room 109 the bathroom door frame was marred with the paint chipped. Inside of the bathroom door was marred across the lower part of the door. The wall under the clock was paint chipped. There was one resident who resided in this room. G. In room 111 the bathroom door was marred with black scuff lines on the inside and the door frame was paint chipped. The legs on the standing dresser were scraped. The paint on the wall register by the window was scraped. There was two residents who resided in this room. H. In room 133 the base of the floor register was scratched and marred. The base of the inside bathroom door was scratched and marred. There were two residents who resided in this room.		recur is: **All staff will be re-educated on identifying environmental concerns and filling out work orders for Maintenance to process.** To ensure the deficient practice does not recur, the monitoring system established is: **All rooms will be audited weekly through the Angel Care Process for any environmental concerns. This tool will continue to be completed weekly for a month, monthly for a quarter, and then quarterly there after with results being forwarded to the PI committee for further review until 100% compliance is achieved.** POC date: 10/6/11	

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	I. In room 110 there was an area of black discoloration on the floor tile under the window between the register vent and the dresser. The paint and plaster was peeling on the corner next to the closet door. The wall in the bathroom next to the sink was paint chipped and scraped. There were two residents who resided in this room. J. In room 137 the porcelain on the inside of the toilet bowl was stained brown and paint chipped. The bathroom wall was also paint chipped. There were two residents who resided in this room. 2. On 9/6/11 during the Environmental Tour at 10:26 a.m., the following was observed on the South Unit: A. In room 014 the bathroom ceiling vent was dusty. There were two residents who resided in this room B. In room 009 the Intravenous pole base was dirty with dried spillage observed on it. There were two residents who resided in this room. 3. On 9/6/11 at 9:55 a.m., the following was observed on the East			

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	Unit during the Environmental Tour: A. The women's shower room stall number two was missing the showerhead. There was an orange mold like substance noted on the bottom of the floor tile about a 15 foot section. The wall tile located at the bottom near the floor was missing an eight foot section along the east side of the shower room wall. The ceiling vent was dusty. The toilet was noted with bowel movement stains on the inside. B. The ceiling vent was dusty in the men's shower room. The light above the sink was burned out. Interview with the Maintenance and Housekeeping Supervisors on 9/6/11 at 11:00 a.m., indicated all of the above mentioned was in cleaning and/or repair. 3.1-19(f)			
F0273 SS=B	A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)			

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	Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days of admission for 6 of 25 residents reviewed for comprehensive assessments. (Resident's #73, #182, #194, #198, #212, & #214) **Findings include:** 1. The record for Resident #198 was reviewed on 9/1/11 at 8:41 a.m. The resident was admitted to the facility on 5/26/11. Review of the Minimum Data Set (MDS) assessment indicated an admission assessment was not completed for the resident until 6/14/11 (19 days after the resident was admitted) Interview with MDS Coordinator #1 on 8/31/11 at 2:30 p.m., indicated the MDS was not completed timely within the first 14 days of admission. Further interview indicated they were under the impression they had 14 days after the Assessment Reference Date (ARD). 2. The record for Resident #182 was reviewed on 9/1/11 at 2:46 p.m. The	F0273	**F – 273** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R198, R182, R194, R214, R73 and R212 were not negatively affected by the deferred assessments. MDS assessments are currently being completed timely per schedule.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Facility to review all current residents to ensure appropriate PPS schedule is being followed.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Case Manager and MDS Staff was re-educated on completing MDS assessments timely.**	10/06/2011

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	resident was admitted to the facility on 6/17/11. The resident was then admitted to the hospital on 6/24/11 and returned to the facility on 6/29/11. Review of the MDS assessment indicated an admission assessment was not completed until 7/15/11 (16 days after the resident was readmitted to the facility). Interview with MDS Coordinator #1 on 9/1/11 at 3:30 p.m., indicated the MDS was not completed timely within the first 14 days of admission. Further interview indicated they were under the impression they had 14 days after the Assessment Reference Date (ARD). 3. The record for Resident #194 was reviewed on 8/31/11 at 2:00 p.m. The resident was admitted to the facility on 7/12/11. Review of the MDS assessment indicated an admission assessment had not been completed until 8/1/11 (20 days after the resident was admitted to the facility) Interview with MDS Coordinator #1 on 8/31/11 at 2:30 p.m., indicated the MDS was not completed timely within the first 14 days of admission.		To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool was developed to monitor timely completion of quarterly MDS's and will be completed by Case Manager weekly for four weeks, then monthly for a quarter, then quarterly thereafter, with results being forwarded by the PI Committee for further review until 100% compliance is met.** POC date: 10/6/11	

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	Further interview indicated they were under the impression they had 14 days after the Assessment Reference Date (ARD). 4. The record for Resident #73 was reviewed on 9/2/11 at 10:18 a.m. The resident was admitted to the facility on 5/18/11. The Admission MDS was reviewed. The MDS was signed and dated as completed on 6/10/11, more than 14 calendar days after admission to the facility. 5. The record for Resident #214 was reviewed on 9/2/11 at 12:20 p.m. The resident was admitted to the facility on 7/7/11. The Admission MDS was signed and dated as completed on 8/18/11. The MDS was completed more than 14 days after the resident was admitted to the facility. 6. The record for Resident #212 was reviewed on 9/2/11 at 10:36 a.m. The resident was admitted to the facility on 7/15/11. The Admission MDS was signed and dated as completed on 8/2/11.			

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	Interview with the MDS Coordinator on 8/31/11 at 2:30 p.m., indicated the Admission MDS was not completed within 14 days of admission. She indicated she was not aware the Admission MDS had to be completed within 14 days of admission to the facility. 3.1-31(d)(1)			
F0278 SS=A	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Based on record review and interviews, the facility failed to ensure each resident's comprehensive assessment was accurately coded related to pressure ulcers for 2 of 25 comprehensive assessments reviewed. (Residents #80 & #194) Findings include: 1. The record for Resident #194 was reviewed on 8/31/11 at 2 p.m. The resident was admitted to the facility on 7/12/11. Review of Physician orders dated 7/13/11 indicated to continue with wound care orders to right lateral ankle cleanse with normal saline apply Santyl (a debriding agent) and cover with a 4 by 4 and kerlix. Further review of Physician orders dated 7/15/11 indicated comfeel to left shoulder pressure ulcer change every 72 hours. Review of the Admission Minimum Data Set Assessment dated 8/1/11 indicated the resident only had one stage two pressure ulcer dated 7/12/11. No other pressure ulcers were recorded on the admission MDS assessment. Interview with MDS Coordinator #1 on	F0278	**F – 278** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Modified MDS's will be completed for R80 and R194.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **All current residents with pressure ulcers will be reviewed to ensure accurate coding on the last MDS assessment.** *The measures put into place and systemic change made to ensure the deficient practice does not recur is:* **MDS staff will be re-educated on proper coding related to pressure ulcers**. To ensure the deficient practice does not recur, the monitoring	10/06/2011

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	155218	A. BUILDING 00 B. WING	09/06/2011

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	8/31/11 at 2:30 p.m., indicated that the MDS was inaccurately coded with only one pressure ulcer at a stage two. 2. On 8/31/11 at 10:10 a.m., LPN #5 and LPN #9 were observed performing wound care for Resident #80. The resident had a stage IV(a wound with full thickness loss) pressure ulcer to the sacral/coccyx area. The wound was approximately 1 cm (centimeter) in diameter and depth was present. The record for Resident #80 was reviewed on 8/31/11 at 8:48 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, malignant neoplasm of the colon, dementia without behavioral disturbances, and abnormal loss of weight.		system established is: **A Performance Improvement tool has been developed to monitor for the accuracy of MDS coding as compared to weekly wound report. Case Manager will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.** POC date: 10/6/11	

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A significant change MDS (Minimum Data Set) full assessment was completed on 7/18/2011. The Assessment Reference Date of the assessment was 6/30/11. The MDS assessment indicated the resident did not have any unhealed pressure ulcers at Stage I or higher.

Review of the 6/2011 Weekly Pressure Ulcer Report indicated the a Stage II pressure ulcer was first observed to the sacral/coccyx area on 6/17/11. The report indicated the June 2011 weekly measurements were as follows:
6/7/11 Stage II 1 cm. x 2 cm.
6/14/11 unstageable-stage IV 1.5 cm. x 1.2 cm.
6/23/11 Unstageable-stage IV 1.6 cm. x 1.6 cm.
6/30/11 Unstageable-stage IV 1.2 cm. x 1/2 cm.

When interviewed on 9/1/11 at 9:11 a.m., MDS coordinator #1 indicated the resident did have an unstageable/Stage IV pressure ulcer during the reference date for the above MDS assessment. The MDS coordinator indicated the MDS was coded incorrectly.

3.1-31(h)

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to ensure a plan of care was initiated related to dental visit refusals for 1 of 3 residents reviewed of the 7 residents who met the criteria for dental services. (Resident #40) The facility also failed to ensure a plan of care was initiated related to range of motion for 1 of 3 residents reviewed of the 7 residents who met the criteria for range of motion. (Resident #126)	F0279	**F – 279** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **A care plan was initiated for R40 related to refusal of dental services. A care plan was**	10/06/2011

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	Findings include: 1. On 8/30/11 at 8:59 a.m., Resident #40 was in room her room seated in her wheelchair. The resident was observed to have few natural teeth left. The record for Resident #40 was reviewed on 8/30/11 at 3:37 p.m. The 8/11 Physician's Order Summary (POS), indicated the resident may see the podiatrist, dentist, optometrist, and ophthalmologist as needed. No current dental progress notes were available for review. Dental progress notes provided by the South Unit Social Service Director, indicated the resident refused her dental visit on 1/27/05 and 5/18/05. Review of the resident's current plan of care, indicated there was no care plan initiated due to the resident's repeated refusals of seeing the dentist. Interview with the resident on 9/1/11 at 8:35 a.m., indicated she had no desire to see the dentist. Interview with the South Unit Social Service Director on 8/31/11 at 3:00		**initiated for R126 related to ROM services.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A whole house review comparing care plans, orders and C.N.A. assignment sheets will be completed. A whole house audit comparing dental service orders, when the resident was last seen by the dentist and individual care plans will be completed. All discrepancies identified will be corrected.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Social Service and the IDT will be re-educated on updating comprehensive care plans related to ancillary services and devices ordered.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool was developed to ensure**	

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	p.m., indicated the resident was last seen by the dentist in 2005 and the resident refused to be seen both times and no longer wanted to be seen. Interview with the South Unit Social Service Director on 9/6/11 at 10:22 a.m., indicated the resident should have had a care plan initiated due to her refusal to see the dentist. Interview with the West Unit Manager on 9/6/11 at 10:22 a.m., indicated there was no current care plan for refusal of care related to dental visits. 2. Resident #126 was observed seated in a wheelchair on 8/31/11 at 8:24 a.m. The resident's left hand was held in a fist position, there was no anti-contracture device noted in her left hand. The record for Resident #126 was reviewed on 8/30/11 at 3:39 p.m. The resident had diagnoses that included, but were not limited to, diabetes and dementia with behaviors. The August 2011 Physician Order Sheet was reviewed. There was an order for a Posey palm grip (an		**that orders, C.N.A. assignment sheets, dental services and care plans all match. DNS or designee will complete PI tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee for further review until 100% is achieved.** POC date: 10/6/11	

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	anti-contracture device) to be placed in the left hand. It was to be placed on the resident during the day and off at night. The form titled "Occupational Therapy Discharge Summary," dated 6/9/11, was reviewed. The Occupational Therapist indicated the resident had a contracture of the left hand and an anti-contracture device was to be issued to the resident. Review of the resident's current care plans indicated there was no care plan for the resident's left hand contracture and the use of the anti-contracture device. Interview with the East Unit Manager on 9/1/11 at 10:05 a.m., indicated there was no care plan related to the contracture of the resident's left hand. 3.1-35(a)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure physician's orders and/or the current plan of care were followed as written related to activity preferences	F0282	**F – 282** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the	10/06/2011

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	for 1 of 3 residents reviewed of 7 residents who met the criteria for activities, nail care not done for 1 of 3 residents reviewed of 7 residents who met the criteria for activities of daily living, labs and medications not initiated as ordered for 2 of 10 residents who were reviewed for unnecessary medications and anti-contracture devices not in place for 1 of 3 residents reviewed of 5 residents who met the criteria for range of motion. (Residents #40, #126, #177, #218 and #219) Findings include: 1. On 8/30/11 at 8:59 a.m., Resident #40 was observed in her room seated in her wheelchair. The resident's right hand was observed to be clinched in a fist. When asked, the resident was able to extend her fingers. The fingernails on the resident's right hand were approximately an inch long. On 9/1/11 at 8:35 a.m., interview with the resident indicated she was not able to cut her fingernails by herself. The resident proceeded to extend the fingers on her right hand and her long fingernails were visible. The resident indicated she would love to have someone cut the nails on her right hand.		following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R219 has been discharged from the facility. R40 received necessary nail care. PT/INR was completed on R218. Eardrops were started on R177. Geri-sleeves were discharged for R126 and palmi-grip was change to carrot per therapy recommendations.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **An audit will be done of all individual activity preferences for all residents on 1:1 and their specific preferences will be added to the C.N.A. assignment sheets. All residents were reviewed for nail care shortcomings and any issues found were immediately addressed. An audit of all orders related to individual devices will be completed and compared to the C.N.A.**	

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	On 9/2/11 at 11:15 a.m., the resident was in her room seated in a wheelchair. Interview with CNA #4 on 9/2/11 at 11:15 a.m., indicated the resident needed assist with nail care. CNA #4 was asked at this time to come to the resident's room and observe the resident's fingernails. The fingernails on the resident's right hand remained approximately an inch long. The CNA proceeded to ask the resident if she would like her nails cut and the resident indicated, "I would love to have them cut." The resident further indicated her fingernails had been digging into the palm of her hand. The record for Resident #40 was reviewed on 8/30/11 at 3:37 p.m. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke) and hemiplegia (muscle weakness). The plan of care dated 1/31/11 and revised as current, indicated the resident had the diagnosis of left side cerebral vascular accident (stroke). The interventions indicated, staff were to assist with ADL's as needed. An order written by the Nurse Practitioner on 9/2/11, indicated to		**assignment sheets for verification. An audit related to Coumadin/Aranesp will be completed to ensure labs were followed through on. An audit of all MAR's was completed to ensure all new orders were being followed appropriately.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All licensed nurses will be re-educated on following facility policy and procedure as it relates to processing new orders and Coumadin/Aranesp tracking. All care staff will be re-educated on ensuring devices are in place as ordered, following individual activity preferences per C.N.A. assignment sheets, and providing nail care as needed.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that will monitor that devices are on as ordered, nail care is done as needed, and individual activity**	

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	please cut the resident's nails and to keep short. Interview with the West Unit Manager on 9/2/11 at 11:20 a.m., indicated the resident's nails needed to be cut. She further indicated nails should be inspected daily with care.		**preferences are being followed. Angels complete PI tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee for further review until 100% is achieved.** **A Performance Improvement tool has been developed that will monitor lab follow through related to Coumadin/Aranesp dosages. DNS or Designee to complete tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee for further review until 100% compliance is achieved.** **A Performance Improvement tool has been developed that will monitor new orders for 3 days to ensure that order was processed and med has been given timely. DNS or Designeed to complete tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee for further review until 100% compliance is achieved.** POC date: 10/6/11	

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	2. On 8/30/11 at 7:07 a.m., Resident #219 was observed in bed with no radio turned on. On 8/31/11 at 8:21 a.m., 10:23 a.m., and 11:22 a.m., the resident was observed in bed with eyes closed, the lights were turned on in the room. There was a radio observed on the bedside table that was not turned on. On 9/1/11 8:21 a.m., the resident was observed in bed with his eyes closed. There was no radio turned on. 9/1/11 at 10:17 a.m., 11:09 a.m., and 1:37 p.m., the resident was observed in bed with his eyes closed. The television was turned on in the room and the radio was off. The record for Resident #219 was reviewed on 8/31/11 at 10:09 a.m. The resident was admitted to the facility on 8/19/11 from the hospital. Review of the Activity Assessment dated 8/21/11 indicated the resident was most active in the morning. The information for the assessment was gathered by his family. The resident appears to listen. The wife brings music with earphones. We will be placing a radio at the bedside. The resident enjoys listening to music now.	F0282	**F – 282** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R219 has been discharged from the facility. R40 received necessary nail care. PT/INR was completed on R218. Eardrops were started on R177. Geri-sleeves were discharged for R126 and palmi-grip was change to carrot per therapy recommendations.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **An audit will be done of all individual activity preferences for all residents on 1:1 and their specific preferences will be added to the C.N.A. assignment sheets. All residents were reviewed for**	10/06/2011

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	Review of Activity Progress Note dated 8/21/11 indicated the resident does not verbalize in response to his name. The resident does open eyes when writer rubbed his arm, however, resident closes eyes within a minute. Activities met with resident's wife. Resident will be resting in bed due to his condition, therefore his goal will be to open his eyes and smile in response to music and conversation during one on one two times a week for 15 minutes. A radio was placed in his room for family and staff to turn on for him. His favorite music was rhythm and blues, jazz, easy listening and spiritual. Staff will be anticipating his needs due to his condition. Review of the current 8/21/11 care plan indicated the resident needs one on one visits due to his condition. The nursing approaches were staff to turn on radio at bedside and staff will also bring music to room. Family indicated he likes blues, jazz, or easy listening. Interview with CNA #2 on 8/31/11 at 3:57 p.m., indicated she rarely works the unit and has not really taken care of the resident before and did not know what the resident's activity preferences were. She further		**nail care shortcomings and any issues found were immediately addressed. An audit of all orders related to individual devices will be completed and compared to the C.N.A. assignment sheets for verification. An audit related to Coumadin/Aranesp will be completed to ensure labs were followed through on. An audit of all MAR's was completed to ensure all new orders were being followed appropriately.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All licensed nurses will be re-educated on following facility policy and procedure as it relates to processing new orders and Coumadin/Aranesp tracking. All care staff will be re-educated on ensuring devices are in place as ordered, following individual activity preferences per C.N.A. assignment sheets, and providing nail care as needed.** To ensure the deficient practice does not recur, the monitoring system established is:	

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	indicated that information was not passed on to her in rounds. Interview with LPN #4 on 9/1/11 at 11:17 a.m., indicated she was unaware of the resident's activity preferences. She indicated she would have to read the Activity Progress Notes for that information. Interview with CNA #3 on 9/1/11 at 11:47 a.m., who normally works on the South Unit and who has worked with the resident before indicated he did not know what the resident's activity preferences were but since the resident does not open up his eyes, he just puts on the television or the radio on. He further indicated the resident's wife brought in a radio but since it was the resident's he indicated he did not like messing with other people's things. Interview with the Activity Director on 9/1/11 at 2:40 p.m., indicated they had brought in a radio for the resident and wife indicated that she would bring her own radio for him to listen to. She further indicated that her or one of her aides communicates with the nursing staff on what the resident's preferences were. She indicated he was to have his radio turned on for stimulation.		**A Performance Improvement tool has been developed that will monitor that devices are on as ordered, nail care is done as needed, and individual activity preferences are being followed. Angels complete PI tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee for further review until 100% is achieved.** **A Performance Improvement tool has been developed that will monitor lab follow through related to Coumadin/Aranesp dosages. DNS or Designee to complete tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee for further review until 100% compliance is achieved.** **A Performance Improvement tool has been developed that will monitor new orders for 3 days to ensure that order was processed and med has been given timely. DNS or Designeed to complete tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	3. The record for Resident #218 was reviewed on 8/31/11 at 8:53 a.m. The resident was admitted to the facility on 8/18/11 from the hospital. The resident's diagnoses included, but were not limited to, obesity, diabetes, deep vein thrombosis, and coronary artery disease. Review of Physician orders dated 8/18/11 indicated a PT/INR (laboratory tests to monitor clotting times) was to be done in the am. Review of the Laboratory data indicated there was no PT/INR completed on 8/19/11. Interview with LPN #3 on 8/31/11 at 10:51 a.m. indicated the PT and INR was not completed on 8/19/11. 4. The record for Resident #177 was reviewed on 8/30/11 at 3:22 p.m. The resident had diagnoses that included, but were not limited to, prostate cancer and hypertension. An audiology report, dated 8/25/11, indicated the resident was seen by an audiologist. The audiologist recommended Debrox or Cerumenex (medications used to soften ear wax) to be used to soften the resident's ear wax for 5-7 days. The audiologist		**for further review until 100% compliance is achieved.** POC date: 10/6/11	

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	155218	A. BUILDING 00 B. WING	09/06/2011

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	indicated a little wax was removed from the left ear and the wax in the right ear was hard. A physician order, dated 8/25/11, indicated "Debrox gtts [drops] to left and right ear q [every] noc [night] for 1 week then take syringe and flush out with warm water." The August 2011 Treatment Administration Record was reviewed. The Debrox was not documented as administered to the resident. The form indicated, "See MAR [Medication Administration Record]. "Review of the August 2011 MAR, indicated the Debrox was not administered to the resident. Interview with LPN #8 on 9/1/11 at 12:05 p.m., indicated the Debrox was not initiated as ordered by the physician. Interview with Resident #177 on 9/1/11 at 12:58 p.m., indicated he was seen by an ear specialist and was supposed to receive some ear drops to soften his ear wax. He indicated he had never received the ear drops. 5. Resident #126 was observed on 8/30/2011 at 8:05 a.m. The resident			

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	was observed to have a 2 inch bruise on her right forearm. There were no geri-sleeves (safety devices to reduce bruises and skin tears) on the resident's arms and there was no palm grip (an anti-contracture device) in her left hand. The resident was observed on 8/31/11 at 8:24 a.m. and at 10:15 a.m. The resident had no geri-sleeves on either arm and no palm grip in her left hand. On 8/31/11 at 11:05 a.m., 1:54 p.m., and 3:28 p.m., the resident was observed with no geri-sleeves on either arm and no palm grip in her left hand. The resident was observed on 9/1/11 at 7:55 a.m. There were no geri-sleeves on her arms and no palm grip in her left hand. The record for Resident #126 was reviewed on 8/30/11 at 3:39 p.m. The resident had diagnoses that included, but were not limited to, diabetes and dementia with behaviors. Review of the August 2011 Physician Order Sheet indicated geri-sleeves were to be worn on the resident's bilateral upper extremities all times,			

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	they could be removed during care and showers. The August 2011 Physician Order Sheet also indicated the resident was to wear a Posey palm grip to the left hand, it was to be in place during the day and off at night. The care plan, dated 5/10/11, indicated the resident had potential for skin breakdown and skin tears due to fragile skin, agitated behaviors and use of aspirin and Plavix (an antiplatelet medication). One of the interventions indicated the resident may continue to use geri-sleeves to her arms. Interview with CNA #6 on 9/1/11 at 9:58 a.m., indicated she was the CNA who provided morning care for the resident on 9/1/11. She indicated she did not apply geri-sleeves and did not place a palm protector in the resident's left hand. She did not have a CNA assignment sheet in her possession at the time of the interview. The East Unit Manager provided a copy of the CNA assignment sheet on 9/1/11 at 10:05 a.m. The sheet indicated the resident was to have a "carrot" (an anti-contracture device) in her left hand, and geri-sleeves on her			

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	arms at all times. Interview with the East Unit Manager, on 9/1/11 at 10:05 a.m., indicated the resident was to have geri-sleeves on at all times as ordered by the physician. She also indicated she was to have a Posey palm grip in her left hand as ordered by the physician. She indicated the resident did not have geri-sleeves on or a palm grip in her left hand. 3.1-35(g)(2)			
F0309 SS=D	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. 1. On 8/29/11 at 3:08 p.m., Resident #218 was observed in bed. At that time there was yellow red bruise noted to her left forearm. On 8/30/11 at 3:00 p.m., the resident was observed in bed. At that time, there was a red and yellow bruise noted to the left forearm. On 8/31/11 at 8:52 a.m., the resident was observed in bed. There was a red and yellow bruise noted to her left	F0309	**F – 309** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **An event report and**	10/06/2011

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	forearm. The record for Resident #218 was reviewed on 8/31/11 at 8:53 a.m. The resident was admitted to the facility on 8/18/11 from the hospital. The resident's diagnoses included, but were not limited to diagnoses obesity, diabetes, deep vein thrombosis, and coronary artery disease. Review of the Patient Nursing Evaluation dated 8/18/11 indicated the resident had no bruises observed to her right forearm. Review of the bath sheets dated 8/23/11 indicated there were no new areas and no bruising. Review of the resident weekly skin check sheet indicated on 8/23/11 there were no new open areas or bruising. The next weekly skin check dated 8/30/11 indicated no bruising. Review of Nursing Progress Notes dated 8/18/11 through 8/31/11 indicated there was no assessment or documentation of any type of bruising to the right forearm. Review of the current plan of care dated 8/18/11 indicated the resident was at risk for abnormal bleeding or		**non-pressure sheets were initiated for R218. R182 physician was notified of the lab out of parameter and was sent to the hospital. An event report and non-pressure sheet was initiated for R126.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A facility skin sweep will be conducted throughout the facility. Any areas unaccounted for will be addressed accordingly. A facility wide audit will be conducted that reviewed the last 30 days of labs to ensure timely follow through. No other areas of concern were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All licensed nurses were re-educated on policy and procedure related to event reporting, non-pressure weekly skin checks, MD notification of abnormal labs in a timely manner, and filling out lab**	

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	hemorrhage because of anticoagulant usage. The nursing approaches were to advise resident to report any symptoms of unusual bleeding or bruising and to monitor for and report to nurse any of the following signs and symptoms of bleeding gums, nose bleeds, and unusual bruising. Interview with the South Unit Manager on 8/31/11 at 10:02 a.m., indicated there were no non pressure ulcer skin sheets with documentation of the bruising including the size. Interview with LPN #3 on 8/31/11 at 10:57 a.m. indicated she was unaware there was a bruise on her right forearm. She further indicated the facility's protocol would be to complete a non pressure sheet with size, color and location of the area. 2. The record for Resident #182 was reviewed on 9/1/11 at 2:46 p.m. The resident was admitted to facility on 6/17/11. The resident's diagnoses included, but were not limited to, high blood pressure and renal insufficiency. Review of Physician Progress Notes dated 6/18/11 indicated Complete Blood Count (CBC) and a Chemistry Metabolic Profile (CMP) on Sunday.		**requisitions appropriately.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool was developed to monitor compliance with facility Policy and Procedure as it relates non-pressure areas. DNS/Designee will complete PI tool weekly for four weeks, then monthly for a quarter, then quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is met.** **A Performance Improvement tool was developed to monitor compliance with facility Policy and Procedure as it relates to timely follow through on abnormal labs. DNS/Designee will complete PI tool weekly for four weeks, then monthly for a quarter, then quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is met.** POC date: 10/6/11	

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Review of the Laboratory data indicated the CMP was only completed. The CBC was not completed on 6/19/11. The results of the CMP were reported to the facility on 6/19/11 at 2:30 p.m. The resident's potassium level was 5.9, a high level (normal 3.5-5.3)

Review of Nursing Progress Notes dated 6/19/11 indicated there was no documentation the resident's physician was notified. Review of the bottom of the 6/19/11 lab results indicated "MD called at 4:20 p.m., and 9:30 p.m., awaiting return call."

Review of Physician orders by the Pulmonologist dated 6/22/11 indicated BMP and CBC in am.

Review of the Lab data dated 6/23/11 indicated the resident's potassium level was 7.2 (a critical level). The abnormal lab results were reported to facility on 6/23/11 at 1:57 p.m.

Review of Nursing Progress notes dated 6/23/11 at 2:30 p.m., indicated the resident's physician was notified of the critical potassium level. The resident's physician then ordered on 6/23/11 a Blood Urea Nitrogen (BUN) and electrolytes stat , and also to give

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	the resident 15 grams of Kayexlate (a medication to lower potassium levels) and 60 cubic centimeters (cc) of Sorbitol and to repeat every hour times three hours, and if not better/same call the physician. Review of the Lab data reported to the facility at 3:10 p.m., indicated a BUN and Creatinine was completed on 6/23/11. There were no results for any electrolytes. Review of Nursing Progress Notes dated 6/23/11 at 6:30 p.m., indicated the Physician was notified and new orders were obtained for a CBC and Electrolytes and to monitor pulse every hour times three hours and then every shift times 3 days. Review of Nursing Progress Notes dated 6/24/11 at 7:10 a.m., indicated the physician was called and new orders were received for a CBC with differential, and CMP if no potassium level from stat found on 6/23/11. Review of the lab data dated 6/24/11 indicated the resident's potassium level was 7.0 (a critical level). The results were reported to the facility at 1:13 p.m., and the resident's physician was notified at 2:15 p.m., with orders to send the resident to the			

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	hospital. Review of Nursing Progress Notes dated 8:30 p.m., indicated the resident was admitted to the hospital with renal failure. The Medication Administration Record (MAR) for 6/17-6/24/11 was not available for review. There was no documentation the Kayexlate or Sorbitol medications were given as ordered. There was no documentation the resident's pulse rate was monitored every hour as ordered. Interview with LPN #2 on 9/2/11 at 2:10 p.m., indicated she called the lab, they indicated they received a requisition on 6/23/11 for a stat BUN/CR not for electrolytes. The lab further indicated they did not draw any electrolytes as a stat draw on 6/23/11. Further interview with the LPN at the time, indicated the lab indicated they only received one requisition on 6/24/11 for CBC and electrolytes to be done. The lab indicated they drew both levels at 11:50 a.m., and not early in the morning. Interview with the South Unit Manager on 9/2/11 at 2:21 p.m., indicated she			

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	was not the unit manager at the time of the hospitalization and she indicated the lytes should have been drawn stat as ordered by the physician on 6/23/11 when the potassium level was critical. She further indicated the physician should have been notified of the abnormal potassium level in a more timely manner when it came back on 6/19/11. Interview with the South Unit Ward Clerk on 9/6/11 at 9:13 a.m., indicated she was unable to find the resident's MAR (Medication Administration Record) from 6/17-6/24/11. Based on observation, record review, and interview, the facility failed to monitor and assess bruising for 2 of 3 residents reviewed for skin conditions of the 6 who met the criteria for skin conditions. (Residents #126 & #218) The facility also failed to ensure the necessary treatment and services were provided related to obtaining and treating abnormal laboratory results timely for 1 of 3 residents reviewed for hospitalization of 7 who met the criteria for hospitalization. (Resident #182)			

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	Findings include: 3. Resident #126 was observed on 8/30/2011 at 8:05 a.m. The resident was observed to have a bruise on her right forearm. There were no geri-sleeves (safety devices to reduce bruises and skin tears) on the resident's arms. The resident was observed on 8/31/11 at 8:24 a.m. She had no geri-sleeves on her arms. On 8/31/11 at 10:15 a.m., the resident was observed with no geri-sleeves on either arm. The bruise on her right forearm was 2 inches by 1 inch in size and was blue and purple in color. On 8/31/11 at 11:05 a.m., 1:54 p.m., and 3:28 p.m., the resident was observed with no geri-sleeves on either arm. The resident was observed on 9/1/11 at 7:55 a.m. There were no geri-sleeves on either arm. The record for Resident #126 was reviewed on 8/30/11 at 3:39 p.m. The resident had diagnoses that included, but were not limited to, diabetes and dementia with behaviors. Review of the August 2011 Physician			

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	Order Sheet indicated geri-sleeves were to be worn on the resident's bilateral upper extremities all times, they could be removed during care and showers. The Physician Order Sheet also indicated the resident was to receive aspirin 81 milligrams daily and Plavix (an antiplatelet medication) 75 milligrams daily. The care plan, dated 5/10/11, indicated the resident had potential for skin breakdown and skin tears due to fragile skin, agitated behaviors and use of aspirin and Plavix. Interventions indicated the resident may continue to use geri-sleeves to her arms and to monitor weekly for breaks in skin integrity. The Nursing Progress Notes were reviewed. An entry dated 8/20/11 at 4:30 a.m. indicated "Upon care of resident bruise noted to left upper thigh. NP [Nurse Practitioner] notified n.o. [new order] to monitor until healed ..." An entry in the Nursing Progress Notes dated 8/22/11 at 4:00 p.m. indicated, "bruise remains to left upper thigh." Review of the weekly skin sheets for August 2011 indicated: 8/2/11 refused- not a shower day 8/9/11 no new issues noted			

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	8/16/11 no new open areas 8/23/11 no new skin issues The bruise observed on the resident's right forearm and the bruise noted on the left upper thigh were not indicated on the August 2011 skin sheets. The policy titled "Non-Pressure Ulcer Prevention and Care," dated 10/31/09, was provided by the Nurse Consultant on 8/31/11. She indicated the policy was current. The policy indicated: "... If a skin injury such as a vascular insufficiency/ischemia (venous stasis and arterial ischemic ulcers), neuropathic, a skin tear, laceration, bruise, burn, etc, should occur or is identified upon admission, document area in resident medical record... ... Assess non-pressure ulcers weekly and document on appropriate designated forms ... ... Assess ulcers for length with and depth ... " Interview with LPN #7 on 9/1/11 at 2:20 p.m. indicated when a bruise was noted the nurse was to first complete an "Event Report" and then was to notify the NP or physician. The			

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	area was to be measured and documented on the form titled, "Weekly Non-Pressure Skin Condition Report." Review of the resident's record indicated there were no "Weekly Non-Pressure Skin Reports" for the bruise on the right forearm or the bruise on the left thigh. Interview with the East Unit Manager, on 9/1/11 at 10:05 a.m., indicated the resident was to have geri-sleeves on at all times as ordered by the physician. She also indicated the resident had a bruise on her right forearm. She indicated there was no documentation related to the bruise on the resident's right forearm in the resident's record. Interview with the East Unit Manager, on 9/1/11 at 11:05 a.m., indicated there were no "Event Reports" completed for the resident's bruise on her right forearm and her left thigh. She also indicated there were no "Weekly Non-Pressure Skin Reports" initiated for the bruises. She indicated the bruises were not assessed and monitored weekly. 3.1-37(a)			

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KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DRIVE DYER, IN46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure 2 of 3 residents of the 7 who met the criteria for Activities of Daily Living were assisted with nail and incontinence care. (Residents #40 and #219) Findings include: 1. On 8/30/11 at 8:59 a.m., Resident #40 was observed in her room seated in her wheelchair. The resident's right hand was observed to be clinched in a fist. When asked, the resident was able to extend her fingers. The fingernails on the resident's right hand were approximately an inch long. On 9/1/11 at 8:35 a.m., interview with the resident indicated she was not able to cut her fingernails by herself. The resident proceeded to extend the fingers on her right hand and her long fingernails were visible. The resident indicated she would love to have someone cut the nails on her right hand. On 9/2/11 at 11:15 a.m., the resident was in her room seated in a	F0312	**F 312** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R40's nail care was completed. R219 no longer resides in the facility.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A review was done of all residents to identify those who were heavier then average with urine incontinence. A check and change program was implemented and these individuals were also added to the C.N.A. assignment sheets. All residents were reviewed for nail care shortcomings and any issues found were immediately addressed.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All care staff will be re-educated on the policies related to nail care and incontinence care.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been**	10/06/2011

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	wheelchair. Interview with CNA #4 on 9/2/11 at 11:15 a.m., indicated the resident needed assist with nail care. CNA #4 was asked at this time to come to the resident's room and observe the resident's fingernails. The fingernails on the resident's right hand remained approximately an inch long. The CNA proceeded to ask the resident if she would like her nails cut and the resident indicated, "I would love to have them cut." The resident further indicated her fingernails had been digging into the palm of her hand. The record for Resident #40 was reviewed on 8/30/11 at 3:37 p.m. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke) and hemiplegia (muscle weakness). A Quarterly Minimum Data Set (MDS) Assessment dated 7/26/11, indicated the resident was extensive assist for personal hygiene with one person physical assist. The Quarterly MDS also indicated the resident had a functional limitation in range of motion which included impairment on one side of upper (shoulder, elbow, wrist and hand) and lower extremities (hip, knee, ankle,		**developed to monitor incontinence care . DNS/designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance has been met. A Performance Improvement tool has been developed to monitor nail care compliance. Angels will complete PI tool weekly for four weeks, monthly for a quarter, and quarterly thereafter, with results being forwarded to the PI committee for further review until 100% is achieved.** POC date: 10/6/11	

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	and foot). The plan of care dated 1/31/11 and revised as current, indicated the resident required extensive assistance with ADL's (activities of daily living) due to hemiplegia/CVA. The interventions indicated staff were to provide cueing and set up as needed to assist with ADL's. The plan of care dated 1/31/11 and revised as current, indicated the resident had the diagnosis of Left side CVA. The interventions indicated, staff were to assist with ADL's as needed. An order written by the Nurse Practitioner on 9/2/11, indicated to please cut the resident's nails and to keep short. Interview with the West Unit Manager on 9/2/11 at 11:20 a.m., indicated the resident's nails needed to be cut. She further indicated nails should be inspected daily with care. 2. On 8/31/11 at 8:27 a.m., CNA #1 was asked to check Resident #219 for incontinence. At that time, the CNA indicated the resident was a two			

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	person assist and she needed assistance in turning and repositioning him. The CNA left the room and returned with the South Unit Manager. The resident was then rolled onto his left side. The resident's sheet was saturated with urine, there were also dried urine rings noted on the sheet underneath the resident, where his bare back was exposed. The resident's incontinent pad was also observed wet with urine with dried urine rings noted. The resident's brief was removed at that time, it was also observed to be wet with a small amount of bowel movement. Interview with CNA #1 at 8:40 a.m., on 8/31/11, indicated she had not changed the resident since she had arrived to the facility at 6:15 a.m. to start her shift. She further indicated she needed two people to turn and change him for incontinence. Further interview with the CNA at that time then indicated the CNA had just remembered that she did check the resident for incontinence by opening his brief only between 7:30 a.m. or 7:40 a.m., she could not remember what time it was exactly. Further interview with CNA #1 at the time, indicated she was the only CNA that			

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	checked him for incontinence even though he was a two person assist to reposition him. The record for Resident #219 was reviewed on 8/31/11 at 10:09 a.m. The resident was admitted to the facility on 8/19/11 from the hospital. The resident diagnoses included, but were not limited to, sepsis, Parkinson's disease, and stroke. Interview with the South Unit Manager on 9/1/11 at 9:43 a.m., indicated the resident should be checked and changed at least every two hours. She further indicated the resident did have dried urine rings on the his sheets as well as the incontinent pad that were both underneath him. She indicated the resident had only been in the facility for 12 days and a comprehensive assessment had not been completed for him yet. Interview with CNA #3 on 9/1/11 at 11:51 a.m., indicated he checks the resident for incontinence at least every 2 hours. He further indicated at that time, the resident was a two person assist. 3.1-38(a)(2)(C) 3.1-38(a)(3)(E)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure a resident who has pressure sores receives the necessary treatment and services to promote healing related to the initiation of treatments and nutritional interventions for 1 of 3 residents reviewed for pressure sores of the 5 who met the criteria for pressure sores. (Resident #194) Findings include: On 9/2/11 at 10:30 a.m., Resident #194 was observed lying in bed while the South Unit Manager performed a pressure ulcer treatment to her right ankle. The pressure ulcer had red surrounding skin with yellow slough noted in the middle. There was minimal drainage noted. The record for Resident #194 was	F0314	**F – 314** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R194's pressure ulcer has progressed positively and the Dietician reviewed for appropriate interventions. MD was made aware of treatment not started timely.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Full facility review of all current treatment orders will be conducted to ensure**	10/06/2011

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	reviewed on 8/31/11 at 2:00 p.m. The resident was admitted to the facility on 7/12/11 from the hospital. The resident's diagnoses included, but were not limited to, right deep vein thrombosis, congestive heart failure, osteoarthritis, anemia, weakness, and malnutrition. Review of 7/12/11 Nursing Admission Assessment indicated the resident had no pressure ulcers, just a left heel old scab, left and right heels were red, and the right ankle was a closed area. Review of the History and Physical by the Nurse Practitioner dated 7/13/11 indicated "right lateral ankle wound minimal serosanginous drainage. Minimal peri-wound erythema. Seeing Physician (name) at wound clinic 7/21/11." Review of Physician orders dated 7/13/11 indicated continue with wound care orders to right lateral ankle-cleanse with normal saline apply Santyl (an ointment to debride wounds) and 4 by 4 (a bandage) and wrap with kerlix (a bandage wrap). Review of the Medication Administration Record indicated the treatment was not signed out as being completed until 7/15/11 (two days		**necessary treatments are signed out as orders as evidenced by licensed nurse signatures and that dietitian recommendation are initiated for residents in a timely matter. Issues will be addressed.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses will be re-educated on timely transcription of orders and pressure ulcer policy and procedure including involving the Dietician when areas are found.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that will monitor follow up and initiation (including dietitian notification) for new skin related concerns.** **DNS/Designee will complete PI tool weekly for four weeks, monthly for a quarter, then quarterly thereafter with results being forwarded to the PI Committee for review until**	

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	after receiving the order). Review of the weekly pressure ulcer report sheet indicated the facility was not able to find the measurements for July 2011. The pressure ulcer report sheet began with the date of 8/12/11. On 8/12/11 the right lateral ankle measured .3 centimeters (cm) by .5 cm. On 8/25/11, the pressure ulcer measured 1 cm. by 1 cm. and was staged at a stage three. The pressure ulcer had white/gray no viable tissue and non adherent yellow tissue. Review of the current 7/13/11 and updated 8/3/11 care plan indicated the resident had a pressure ulcer the right lateral malleolus (ankle). The nursing approaches were to institute weekly pressure ulcer condition report, and follow physician orders for skin care and treatments. Review of the Nutrition assessment dated 7/12/11 indicated the resident had no pressure ulcers. Review of the SNAR (Skin and Nutrition at Risk) meeting notes dated 7/14/11 indicated the resident's weight was 98 pounds and she had no pressure ulcers. The Registered Dietitian (RD) recommended a		**100% compliance has been met.** POC date: 10/6/11	

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nutritional supplement of 2 cal HN 90 cc (cubic centimeters) with medication pass three times a day (TID).

Further review of the SNAR notes dated 7/21/11 indicated the resident had no pressure ulcers and to continue weekly review.

Review of Nutritional Progress Notes by the RD on 7/26/11 indicated the resident being reviewed for pressure ulcers. The RD recommended a multivitamin, and to increase the 2 cal HN to 180 cc TID with medication pass and finally to liberalize her diet to mechanical soft.

Review of Physician orders dated 7/21/11 indicated the nutritional supplement of 2 cal HN 90 cc TID with medication pass was ordered. Physician orders dated 7/28/11 indicated to increase the 2 cal HN to 180 cc TID with medication pass, multivitamin with minerals 1 tablet daily, and to change the diet to mechanical soft and discontinue the sodium restriction.

Review of Nursing Progress Notes dated 7/21/11 indicated the wound clinic had called and had rescheduled the resident's visit to 7/28/11. Review of Nursing Progress Notes dated

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	7/28/11 indicated there was no documentation the resident was sent to the wound clinic. Interview with the South Unit Manager on 8/31/11 at 3:40 p.m., indicated she contacted the wound clinic regarding the visit on 7/28/11 and they indicated they have no hard chart for the resident therefore they have no dictated notes. The wound clinic further indicated if the resident was sent there by herself and was unable to sign papers they just probably sent her back to the facility without treatment. The South Unit Manager indicated she was not the Unit Manager at that time. Interview with the South Unit Ward Clerk on 9/6/11 at 11:01 a.m., indicated she was still not able to find the pressure ulcer weekly report sheet with measurements of the right ankle for the month of July 2011. Interview with the Nurse Practitioner on 8/31/11 at 3:57 p.m., indicated the pressure sore actually worsened a little so the treatment had been changed. Interview with the RD on 9/6/11 at 8:58 a.m., indicated she has just been the RD for the facility since 8/1/11. She indicated the procedure for			

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	ensuring dietary was aware of pressure ulcer was that she was given the pressure ulcer weekly log to identify any resident with pressure ulcers. She indicated the pressure ulcer should have been identified during the first SNAR meeting with interventions put into place. 3.1-40(a)(2)			
F0318 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure residents who had a limitation in range of motion received services to prevent further decline in range of motion related to anti-contracture devices not applied as scheduled for 1 of 3 residents reviewed for contractures of the 4 who met the criteria for contractures. (Resident #126) Findings include: 1. Resident #126 was observed on 8/30/2011 at 8:05 a.m. The resident did not have a palm grip (an	F0318	**F – 318** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R126 now wears a carrot in her left hand per MD order.** The corrective action taken for those residents having the	10/06/2011

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	anti-contracture device) in her left hand. The resident was observed on 8/31/11 at 8:24 a.m. and at 10:15 a.m. The resident had no palm grip in her left hand. On 8/31/11 at 11:05 a.m., 1:54 p.m., and 3:28 p.m., the resident was observed with no palm grip in her left hand. The resident was observed on 9/1/11 at 7:55 a.m. There was no palm grip in her left hand. The record for Resident #126 was reviewed on 8/30/11 at 3:39 p.m. The resident had diagnoses that included, but were not limited to diabetes and dementia with behaviors. Review of the August 2011 Physician Order Sheet indicated the resident was to wear a Posey palm grip to the left hand and it was to be in place during the day and off at night. The form titled, "Occupational Therapy Discharge Summary," dated 6/9/11, was reviewed. The Occupational Therapist completed the form and indicated the resident had been treated for contracture		potential to be affected by the same deficient practice is: **A facility wide audit will be conducted to ensure that all ordered devices are on as ordered and current on the C.N.A. assignment sheets. Issues will be addressed.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All care staff will be re-educated on verification of the use of assistive devices as dictated on the C.N.A. assignment sheets.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed to monitor device usage. Angels will complete PI tool weekly for four weeks, monthly for a quarter, and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been achieved.** POC date: 10/6/11	

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	management of the left hand. He indicated a palmer positioning device had been ordered for the left hand and would be issued to the resident when it arrived. The resident was observed on 9/1/11 at 9:00 a.m. The resident did not have the Posey palm grip in her left hand. Interview with the Occupational Therapist on 9/1/11 at 9:00 a.m., indicated the resident did not have a palm protector in left hand. He indicated she was to have an anti-contracture device in her left hand. Interview with CNA #6 on 9/1/11 at 9:58 a.m., indicated she was the CNA who provided morning care for the resident on 9/1/11. She indicated she did not place a palm protector in the resident's left hand. She did not have a CNA assignment sheet in her possession at the time of the interview. The East Unit Manager provided a copy of the CNA assignment sheet on 9/1/11 at 10:05 a.m. The sheet indicated the resident was to have a "carrot" (an anti-contracture device) in her left hand.			

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	Interview with the East Unit Manager on 9/1/11 at 10:05 a.m., indicated the resident was to have a Posey palm grip in her left hand as ordered by the physician, she indicated the resident did not have the Posey palm protector in her left hand. 3.1-42(a)(2)			
F0329 SS=G	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 2. The record for Resident #198 was reviewed on 9/1/11 at 8:41 a.m. The resident's diagnoses included, but were not limited to obesity, anemia, high blood pressure, pneumonia, respiratory failure, tracheotomy, and	F0329	**F – 329** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:	10/06/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	peg tube. The resident was admitted to the facility on 5/26/11 from the hospital. Review of Physician orders dated 5/26/11 indicated Xanax .25 milligrams as needed (prn). Further review of Physician orders dated 6/3/11 indicated Xanax .25 mg twice a day. Review of Nursing Progress Notes dated 5/26-6/3/11 indicated there was no documentation of the resident having anxiety or exhibiting signs and symptoms of anxiety. Review of Physician Progress Notes dated 6/1 and 6/8/11 indicated there was no documentation of why the resident was started on routine Xanax on 6/3/11. Review of Social Service Progress Notes from 6/3-8/31/11 indicated there was no documentation regarding the resident receiving routine Xanax. Interview with the South Unit Social Service Director on 9/1/11 at 10:17 a.m., indicated she was unaware the resident was taking routine Xanax. She further indicated she does not have any progress notes regarding		The corrective action taken for the residents found to have been affected by the deficient practice was: **R198 no longer resides in the facility. Recommendation has been made for R131 for psychiatric eval and med review. Physician orders have been clarified for anti-coagulant monitoring for R174..** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Full facility audit related to residents requiring the use of psychotropic drugs will be completed to ensure that diagnosis for med use is in place and non-pharmacological interventions are offered prior to medication administration. Issues will be addressed. Full facility audit related to Anti-coagulant agent use will be completed to ensure related labs are in place and being followed. Issues will be addressed.** The measures put into place and systemic change made to ensure the deficient practice does not	

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	the resident being on routine Xanax. The South Unit Social Service Director also indicated at the time, there was no documentation in Physician Progress Notes regarding the Xanax. 3. The record for Resident #131 was reviewed on 8/30/11 at 3:11 p.m. The resident admitted to the facility on 12/1/10. The resident's diagnoses included, but were not limited to, senile psychotic condition, vascular dementia with depressed mood, and psychosis. Review of the 3/25/11 quarterly Minimum Data Set (MDS) assessment indicated the resident was not interviewable and had no behaviors noted. The resident's active diagnoses included dementia and depression. Review of Physician orders dated 8/15/11 indicated Ativan 1 mg sublingual (under the tongue or on the side of the mouth) every 4 hours prn (as needed) for terminal restlessness and anxiety. Review of the Medication Administration Record (MAR) for the month of 8/11 indicated the Ativan was signed out as being given on		recur is: **All licensed nursing will be re-educated on psychotropic drug use including ensuring a diagnosis for use is in place and non-pharmacological interventions are offered prior to medication administration. Nurses will be re-educated on anti-coagulant monitoring is in place pre MD orders.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool related to monitoring psychotropic drug use for non-pharmacological interventions and diagnosis for use will be completed weekly by the DNS or designee. This tool will continue to be completed weekly for a month, monthly for a quarter, and then quarterly there after with results being forwarded to the PI committee for further review until 100% compliance is achieved.** **The anti-coagulation record will be reviewed daily by Nursing Administration to ensure lab testing is current per MD order. This will be on-going.**	

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	8/12, 8/16, 8/17, 8/20, 8/21, 8/22, 8/25 and 8/27/11. Review of the back side of MAR indicated on 8/12/11 the resident was restless, on 8/18 the resident was yelling out-agitation, and on 8/20 the resident was yelling out-restless. There was no other documentation on the back of MAR as to why the resident received the prn Ativan. Review of Nursing Progress Notes indicated there was no documentation on 8/16, 8/17, 8/20, 8/21, and 8/27/11 of why the resident received the prn Ativan. Interview with LPN #1 on 9/1/11 1:50 p.m., indicated nurses were required to document in Nursing Progress Notes any interventions tried first before giving the prn medication as well as why the medication was being given. Interview with East Unit Manager on 9/1/11 at 2:04 p.m., indicated the nurses were to document in Nursing Progress Notes interventions tried first before giving a prn medication as well as the reason. 3.1-48(a)(3) 3.1-48(a)(4)		POC date: 10/6/11	

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	Based on observation, record review, and interview, the facility failed to monitor the continued use of an anticoagulant medication related to the lack of obtaining laboratory results during the use of anticoagulant medications for 1 of 1 resident reviewed for renal dialysis in the stage 2 sample of 53 which resulted in the need to hospitalize the resident for gastrointestinal bleeding and the need for plasma infusions. (Resident #174) The facility also failed to ensure each resident was free from unnecessary medications related adequate indications for the use of Xanax and Ativan (both antianxiety medications) for 2 of 10 residents reviewed for unnecessary medications. (Residents #131 and #198) Findings include: 1. The record for Resident #174 was reviewed on 9/1/11 at 2:12 p.m. The resident was admitted to the facility on 6/29/11 and was sent to the hospital on 8/3/11. The resident was readmitted to the facility from the hospital on 8/26/11. The resident's diagnoses included, but were not limited to, end stage renal disease, renal dialysis, high blood pressure, gastro intestinal			

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	bleed, and coagulopathy. Review of the 8/3/11 Physician orders indicated an order was written on 8/3/11 to send the resident to the hospital for an evaluation due to low blood pressure. Review of the 6/29/11 admission Physician orders indicated there was an order for the resident to receive Jantoven (an oral medication to decrease blood clotting time) 3 milligrams daily at 5:00 p.m. The order also indicated the Jantoven was to be held if the INR (a laboratory test to determine clotting time) was greater than 3.5. There was also an order to obtain a PT/INR laboratory test on 6/30/11. There were no other orders for any further or ongoing INR laboratory tests to be completed. A care plan initiated on 6/29/11 indicated the resident was receiving long term anticoagulant therapy. Care plan approaches were for staff to administer the medication as ordered, monitor PT/INR levels as ordered, monitor the resident for symptoms of bleeding, and to report all lab results to the MD or Nurse Practitioner. Review of 6/30/11 laboratory results			

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	indicated the INR level was 2.20. The results were signed as reviewed by the Physician. The results did not indicate the date the Physician signed the results. Review of the 7/2011 laboratory results indicated there was no documentation of any further INR test results. Physician progress notes were completed by the physician on 6/30/11, 7/5/11, 7/12/11, 7/19/11, 7/21/11, and 7/27/11. The 7/2011 Medication Administration Record was reviewed. The Jantoven 3 milligrams was signed out as given daily 7/1/11 through 7/31/11 with no documentation of any INR laboratory results documented. Review of a hospital History and Physical report dictated on 8/4/11 indicated the resident was admitted to the hospital on 8/3/11. The report indicated the residents INR results were greater than 10 upon admission to the hospital. The impression and plan on the report indicated hemorrhagic and hypovolemic shock and coagulopathy secondary to warfarin (Jantoven) toxicity. The resident was transfused with 2 units of fresh frozen plasma on 8/3/11 and was to receive another unit on 8/4/11. A physician consult completed in the hospital dated 8/11/11 indicated the			

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	resident was receiving anticoagulation therapy secondary to a history of a mitral valve (a heart valve) replacement and now presented with an INR of 10 leading to a gastrointestinal bleed. The facility policy titled "Coumadin Dosing" was presented by the Director of Nursing on 9/2/11 at 11:05 a.m. The Director of Nursing identified the policy as current. The policy was dated 10/31/06. The policy indicated a Coumadin Anticoagulation Record was to be completed. The dose of the Coumadin and results of any INR tests were to be recorded on the form. When interviewed on 9/2/11 at 1:20 p.m., the South Unit Nursing Manager indicated the Anticoagulation Record for Resident #174 could not be located. When interviewed on 9/2/11 at 9:59 a.m., the Director of Nursing indicated there were no further INR laboratory tests completed between 6/30/11 and 8/3/11 while the resident was receiving Jantoven (Coumadin) doses daily.			

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F0368 SS=F	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. 3. A confidential interview was completed with Resident #C on 8/29/11 at 12:55 p.m. The resident was seated at a table in the Main Dining Room. The resident had not been served his meal tray at this time. No other residents in the dining room had been served their meal trays at this time either. The resident pointed to his watch and indicated the meal trays are sometimes served over an hour and a half late. 4. A confidential interview was completed with Resident #B on 8/29/11 at 1:15 p.m. The resident was seated at table in the Main Dining Room. The resident indicated her meal tray was late and sated they are "late every meal." The resident	F0368	**F – 368** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **No residents were directly affected by meals being served outside the 14 hour established parameter.** The corrective action taken for those residents having the potential to be affected by the	10/06/2011

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	indicated the meal is supposed to be served at 12:30 p.m. and is usually served after 1:00 p.m. 5. A confidential interview was completed with Resident #A on 8/29/11 at 12:55 p.m. The resident was seated at a table in the Main Dining Room. The resident had not been served her lunch meal. No other residents in the dining room had been served their meal trays at this time either. The resident indicated the meal trays are supposed to be served at 12:30 p.m. and they area usually served around 1:00 p.m. 3.1-21(c) 3.1-21(d)		same deficient practice is: **Meal times have been changed to ensure no more then 14 hours between a substantial evening meal and breakfast the following day.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All dietary staff has been re-educated on serving meals no more then 14 hours between evening meal and breakfast the following day.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool was developed to monitor timeliness of meal service. ED will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been achieved.**	

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	Based on observation and interview, the facility failed to ensure there were no more than 14 hours between a substantial dinner meal and the breakfast meal. The facility also failed to ensure meals were served at the times posted in the facility, for 4 of 4 dining rooms. This had the potential to affect 126 residents who consumed food from the facility kitchen out of a total population of 131. (South Dining Room, East Dining Room, West Dining Room, and the Main Dining Room) Findings include: 1. A posting outside of the entrance to the Main Dining Room was observed on 8/29/11 at 10:15 a.m. The posting listed the meal times for the facility's 4 dining rooms as follows: BREAKFAST: South Dining Room 7:20 a.m. West Dining Room 7:35 a.m. East Dining Room 8:00 a.m. Main Dining Room 8:30 a.m. LUNCH South Dining Room 11:35 a.m. West Dining Room 11:55 a.m. East Dining Room 12:20 p.m. Main Dining Room 12:30 p.m.		POC date: 10/6/11	

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DINNER
South Dining Room 5:00 p.m.
West Dining Room 5:20 p.m.
East Dining Room 5:45 p.m.
Main Dining Room 6:00 p.m.

There were more than 14 hours between the evening meal and the breakfast meal of the following day. The South Dining Room was scheduled to be served breakfast at 7:20 a.m. That was 14 hours and 20 minutes after dinner was scheduled to be served on the previous day.

The West Dining Room was scheduled to be served breakfast at 7:35 a.m. That was 14 hours and 15 minutes after dinner was scheduled to be served on the previous day.

The East Dining Room was scheduled to be served breakfast at 8:00 a.m. That was 14 hours and 15 minutes after dinner was scheduled to be served on the previous day.

The Main Dining Room was scheduled to be served breakfast at 8:30 a.m. That was 14 and 1/2 hours after dinner was scheduled to be served on the previous day.

Interview with the Administrator on

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	9/1/11 at 9:20 a.m. indicated there was greater than 14 hours between the dinner meal and the breakfast meal on the following day. She indicated the facility's Resident Council meets regularly. She indicated there had not been any agreement, provided by the Resident Council, that indicated approval for maintaining the meal times as scheduled with greater than 14 hours lapsing between the dinner meal and the breakfast meal. 2. The lunch meal was observed on 8/29/11. The meal trays arrived at the South Dining Room at 12:08 p.m., 33 minutes after the posted time of 11:35 a.m. The meal trays were delivered to the West Dining Room at 12:30 p.m., 35 minutes after the posted time of 11:55 a.m. The meal trays arrived at 12:46 p.m. in the East Dining Room, 26 minutes after the posted meal time of 12:20 p.m. Observation in the Main Dining Room			

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	on 8/29/11 at 12:55 p.m., indicated 40 residents were seated. No meal trays had been passed. At 1:05 p.m. the first meal tray was passed, 35 minutes after the posted meal time of 12:30 p.m. Interview on 9/2/11 at 1:20 p.m., with the East Unit Manager, indicated meals were served late on 8/29/11. On 9/6/11 at 10:30 a.m., the Registered Dietician was interviewed. She indicated meals had not been served at the times that were posted.			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure all food was stored and prepared under sanitary conditions related labeling and dating food in refrigerators, dirty and greasy griddle, can opener, coffee maker, and stove area for 1 of 1 kitchens and 3 of 3 food pantries. This had the potential to affect 126 residents of the 131 residents who resided in the facility. (The main kitchen, the South, East, and West	F0371	**F – 371** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **All unlabeled food items in the**	10/06/2011

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	pantries) Findings include: 1. On 9/6/11 at 10:11 a.m., the pantry on the East Unit was observed. Inside the refrigerator there was a styrofoam cup of milk with no label or date and one cup of dried cereal with no label or date. There were two meat sandwiches with no label or date. One bottle of bottled water that was opened with no date. 2. On 9/6/11 at 10:50 a.m. the following was observed in the refrigerator in West Unit pantry: A. One tray with two meat sandwiches with no date or label on the wrappers. 3. On 9/6/11 at 10:22 a.m., the following was observed in the South Unit pantry in the refrigerator: A. Two wax paper baggies with two slices of bread each that were hard to touch with no date or label. B. One ham sandwich with no date or label. C. One plate with a bologna sandwich that was wrapped and		**East Unit pantry, West Unit pantry, South Unit pantry and the kitchen were immediately discarded. The griddle, can opener, coffee maker and stove were all cleaned.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A daily cleaning schedule was implemented to include all foods were labeled and dated as appropriate in addition to general cleanliness of the kitchen.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Dietary department has been re-educated on cleanliness and sanitation. All staff has been re-educated on labeling and dating items placed in refrigerators.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool related to cleanliness and sanitation will be completed weekly by the ED or designee. This tool will continue to be**	

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	dated 9-2 to 9-4. D. One plate that was covered with tin foil and had half eaten BBQ ribs and baked beans no date or label. E. One ham sandwich in a bag with no date or label. Interview with the Housekeeping Supervisor on 9/6/11 at that time, indicated there were no dates on the sandwiches, food, or the bread noted in the above refrigerators. 2. During the brief kitchen tour on 8/29/11 at 9:31 a.m., the following was observed: A. There was a plastic container with 6 hot dogs on the shelf in the walk in-refrigerator. There was no label on the container that indicated the product or the date the product was placed in the refrigerator. B. There was a meat mixture contained in a pan. Interview with Cook #1, at the time of the tour, indicated the pan contained sloppy Joe mixture. There was no label on the pan to indicate what the product was. There was no label to indicated		**completed weekly for a month, monthly for a quarter, and then quarterly there after with results being forwarded to the PI committee for further review until 100% compliance is achieved.** POC date: 10/6/11	

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	155218	A. BUILDING 00 B. WING	09/06/2011

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	when the product was placed in the refrigerator. C. There was a package of meat labeled "Deli Roast Beef." There was a "Use by" label on the meat. The label indicated the "Use by" date was 8/24/11. D. There was a metal pan, 24" by" 36" in size, the product was identified by Cook #1 to be cake. There was a sheet of waxed paper covering the pan. 7 slices of cake were removed. There was no date on the cover to indicate when the cake was baked and placed in the refrigerator. There was no label to indicate what the product was. E. There was a container of cottage cheese observed in the reach-in cooler. The container was half full. On the bottom of the container was a statement that indicated, "Date Best by 8/25/11." Interview with the Registered Dietician at the time of the brief kitchen tour, indicated all items in the refrigerator, not in the original container, were to be labeled with the contents and dated when first placed in the refrigerator. All items were to be discarded if out of date.			

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	3. During the kitchen tour on 9/6/11 at 9:50 a.m., the following was observed: A. The griddle was soiled and in need of cleaning. B. The metal backsplash of the stove was soiled with food splatter and was in need of cleaning. C. The racks, doors, and interior surfaces of the convection oven were soiled with food splatter and was in need of deep cleaning. D. The coffee maker was soiled with coffee splatter and was in need of cleaning E. The cutting surface of the can opener was soiled and in need of cleaning. Interview with the Dietary Manager at the time of the kitchen tour, indicated all of the above areas were in need of cleaning. 3.1-21(i)(3)			

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F0412 SS=D	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on record review, and interview, the facility to ensure routine dental services were provided for 2 of 3 residents reviewed for dental status of the 6 that met the criteria for dental status and services. (Residents #15 & #80) Findings include: 1. The record for Resident #15 was reviewed on 8/31/11 at 1:59 p.m. The resident was admitted to the facility on 12/4/2008. The resident's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure high blood pressure, and depressive disorder. Review of the 8/11 Physician Order Statement indicated there was an order written on 1/17/2011 which noted the resident could be seen by the dentist as needed. There were no dental consults or dental visit reports	F0412	**F – 412** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R 15 refused to be seen by the dentist. Her care plan was updated accordingly. R80 has been seen by the dentist.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A full house audit related to timeliness of dental services will be conducted. All residents**	10/06/2011

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	in the resident's record. When interviewed on 9/1/11 at 8:25 a.m., the West Unit Social Service Director indicated there was no documentation in the resident's record related to any recent dental visits. The Social Service Director indicated the resident's payor source has been Medicaid. The Social Service Director indicated a new dental provider service began around 2/2010. The Social Service Director indicated there was record of the resident being seen by the new dental service provider. When interviewed on 9/2/11 at 8:20 a.m. the West Unit Social Service Director indicated the resident should have been seen by the dentist. When interviewed on 9/2/11, the resident indicated the last time she was seen by the dentist at the facility was around 2-3 years ago. 2. The record for resident #80 was reviewed on 8/31/11 at 8:48 a.m. The resident was admitted to the facility on 8/2/2008. The resident's diagnoses included, but were not limited to, osteoarthrosis, malignant neoplasm of the colon, dementia and depressive disorder.		**needing to be seen will be referred to the dentist.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Social Service will be re-educated on timeliness of dental services.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement Tool has been developed to monitor for timeliness of dental services. Social Service or designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.** POC date: 10/6/11	

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	Review of a 3/11/10 Care Plan Conference Summary note indicated the resident needed a dental appointment. A consent to authorize (name of dental provider) was signed by the residents daughter on 3/11/2010. The consent gave authorization for the resident to be seen by the dentist/hygienist. When interviewed on 8/31/11 at 1:43 p.m., the west unit Social Service Director indicated resident had not been seen by the dentist since the 3/11/2010 care conference summary. The most recent dental visit consult was 4/30/09. The 4/30/09 consult indicated the resident was having pain in some root tips. There were no further dental visits available in the resident's record. 3.1-24(a)(1)			

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F0425 SS=E	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to ensure multi-dose vials of expired insulin were not in use. This had the potential to affect 3 of 9 insulin dependent diabetics who resided on the South Unit and 7 of 10 insulin dependent diabetics who resided on the East Unit. (Residents #8, #10, #28, #105, #119, #151, #154, #176, #197 and #198) Findings include: 1. On 9/2/11 at 9:08 a.m., a vial of Lantus insulin for Resident #197 was observed in the South Unit Medication Cart, the insulin had not been dated when opened. The South Unit	F0425	**F – 425** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **The expired insulin was immediately discarded and replaced.** The corrective action taken for those residents having the potential to be affected by the	10/06/2011

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	Manager indicated the insulin had been delivered to the facility on 7/14/11. Review of the 9/11 Medication Administration Record (MAR), indicated the resident had a current order for Lantus inject 30 units subcutaneously (sq) at bedtime. The resident had received the insulin on 9/1/11. Interview with the South Unit Manager at the time, indicated the resident had another vial of Lantus in the cart that was delivered on 8/20/11 and it was not dated when opened. She indicated that she did not know which vials of Lantus the staff had been using. 2. On 9/2/11 at 9:25 a.m., a vial of Novolog insulin was observed in the South Medication Cart for Resident #119. The vial of insulin was dated as opened 7/6/11. Review of the 9/11 MAR, indicated the resident was to receive the Novolog insulin based on a sliding scale before meals. The MAR, indicated the resident had received 6 units of the Novolog insulin on 9/2/11 at 7:00 a.m. The resident also had a vial of Lantus insulin in the South Medication Cart that was delivered to the facility on 7/5/11, there was no date as to when		same deficient practice is: **A full facility audit of all medication carts, med rooms, and med room refrigerators was conducted to ensure that no other insulin vials had expired. No other issues were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses will be re-educated on the importance of checking expiration dates prior to administration of any medications.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed to monitor for expired insulin. DNS will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.**	

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	the vial of insulin was opened. Review of the 9/11 MAR, indicated the resident had a current order for Lantus 10 units sq at bedtime. The resident had received the Lantus the previous night. Interview with the South Unit Manager at the time, indicated multi-dose vials of insulin were considered expired after 28 days of being opened. 3. On 9/2/11 at 9:30 a.m., a vial of Novolin Regular insulin was observed in the South Unit Medication Cart for Resident #198. The vial of insulin was dated as being dispensed on 5/23/11. There was no date on the vial of insulin as to when it was opened. Interview with the South Unit Manager at 9:36 a.m., indicated the resident was no longer receiving insulin coverage. She further indicated the resident had not received insulin since her admission to the facility on 5/26/11. 4. On 9/2/11 at 9:42 a.m., two vials of Novolog insulin for Resident #151 were observed in the East Unit Medication Cart. One of the vials was delivered to the facility on 7/20 and another vial was delivered on 7/21/11.		POC date: 10/6/11	

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	The vials were not dated when opened. Review of the 9/11 MAR, indicated the resident had a current order to give the Novolog based on a sliding scale before meals and at bedtime. Review of the 9/11 MAR, indicated the resident had received 4 units of Novolog insulin on 9/2/11 at 6:00 a.m. Three vials of Lantus insulin were also observed in the medication cart. One of the vials had been delivered to the facility on 6/25/11, and the others had been delivered on 7/20 and 8/11/11. All three vials had not been dated when opened. Review of the 9/11 MAR, indicated the resident had a current physician's order for Lantus 12 units sq at bedtime. Interview with LPN #5 at the time, indicated the vials of Novolog and Lantus that had been delivered to the facility in June and July should have been discarded. She further indicated it would be hard to determine which vial of Lantus the resident had been receiving since three vials were opened. 5. On 9/2/11 at 9:45 a.m., three vials of Novolog insulin for Resident #28 were observed in the East Unit Medication Cart. The Novolog insulin			

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	had been delivered to the facility on 5/1, 5/25, and 6/4/11. All three vials had not been dated when opened. Review of the 9/11 MAR, indicated the resident had a current physician's order to give the Novolog insulin based on a sliding scale. Review of the 8/11 MAR, indicated the resident had received 2 units of the Novolog on 8/31/11 at 5:00 p.m. 6. On 9/2/11 at 9:50 a.m., a vial of Lantus insulin for Resident #176 was observed in the East Unit Medication Cart. The vial was delivered to the facility on 5/1/11 and not dated when opened. Review of the resident's record on 9/2/11 at 2:45 p.m., indicated the resident had been readmitted to the facility on 5/12/11 and 8/23/11 with no physician's orders for Lantus insulin. 7. On 9/2/11 at 9:55 a.m., a vial of Lantus insulin for Resident #105 was observed in the East Unit Medication Cart. The vial of insulin was dated as opened on 6/15/11. Review of the 9/11 MAR, indicated the resident had a current physician's order for Lantus 18 units sq at bedtime. The Lantus was last signed out on the MAR on 9/1/11 at 9:00 p.m.			

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	A vial of Novolog insulin was also observed in the medication cart. The vial was dated as opened on 6/2/11. Review of the 9/11 MAR, indicated the resident had a current physician's order for Novolog insulin 10 units sq with breakfast. The insulin was last signed out as given on 9/2/11 at 8:00 a.m. 8. On 9/2/11 at 10:00 a.m., two vials of Novolog insulin for Resident #8 were observed in the East Unit Medication Cart. The vials of insulin were delivered to the facility on 4/5 and 4/11/11, they were not dated when opened. The record for the resident was reviewed on 9/2/11 at 3:05 p.m., the resident was re-admitted to the facility on 6/24/11 with no orders for insulin. Review of the 9/11 Physician's Order Summary, indicated the resident had no current insulin orders. 9. On 9/2/11 at 10:05 a.m., two vials of Novolog insulin for Resident #154 were observed in the East Unit Medication Cart. One vial was delivered to the facility on 3/11/11 and the other vial was delivered on 6/17/11. Both vials were not dated when opened. Review of the 9/11 MAR, indicated the resident was to			

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	receive 8 units of the insulin with breakfast, 7 units with lunch and 6 units daily at dinner. The Novolog insulin had been signed out as given on 9/1/11 at 5 p.m. and 9:00 p.m., and 9/2/11 at 7:00 a.m. 10. On 9/2/11 at 10:10 a.m., a vial of Lantus insulin for Resident #10 was observed in the East Unit Medication Cart. The vial of insulin had been dated as opened on 7/15/11. Review of the 9/11 MAR, indicated the resident was to receive 4 units of the Lantus insulin at bedtime. The facility policy titled "Insulin with Special Expiration Date Requirement" was reviewed on 9/2/11 at 11:05 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated Lantus and Novolog insulin should be discarded 28 days after being opened. The policy also indicated Novolin Regular insulin should be discarded 30 days after being opened. 3.1-25(o)			

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F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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, record review and interview, the facility failed to ensure multi dose vials of insulin were dated when opened. This had the potential to affect 1 of 10 insulin dependent diabetics on the West Unit, 5 of 9 insulin dependent diabetics on the South Unit and 3 of	F0431	**F – 431** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for	10/06/2011

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	10 insulin dependent diabetics on the East Unit. (Residents #52, #107, #141, #151, #154, #197, #217, #220, and #221) Findings include: 1. On 9/2/11 at 8:50 a.m., a vial of Lantus insulin for Resident #107 was observed in the West Unit Medication Cart. The Lantus was delivered to the facility on 8/16/11 but was not dated when opened. Interview with LPN #6 at the time, indicated the vial of insulin should have been dated when opened. 2. During observation of the South Unit Medication Cart on 9/2/11 at 9:08 a.m., the following was observed: a. A vial of Lantus insulin for Resident #197 was delivered to the facility on 8/20/11. The vial of insulin had not been dated when opened. There was also a vial of Novolog insulin that had been delivered to the facility on 8/28/11 that had not been dated when opened. b. A vial of Novolin 70/30 insulin for Resident #221 had been delivered to the facility on 8/18/11. The vial of insulin was not dated when opened.		the residents found to have been affected by the deficient practice was: **The non dated insulin was immediately discarded and replaced.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A full facility audit of all medication carts, med rooms, and med room refrigerators was conducted to ensure that all multi-dose vials of insulin were dated when opened. No other issues were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses will be re-educated on the importance of labeling multi-dose vials when opening.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed to ensure multi-dose vials are**	

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	c. A vial of Novolog insulin for Resident #217 was delivered to the facility on 8/28/11. The vial of insulin was not dated when opened. d. A vial of Novolog insulin for Resident #141 was delivered to the facility on 8/28/11. The vial of insulin was not dated when opened. e. A vial of Novolog insulin for Resident #220 was delivered to the facility on 8/27/11. The vial of insulin was not dated when opened. Interview with the South Unit Manager at the time, indicated the vials of insulin were to be dated when opened. 3. During observation of East Unit Medication Cart on 9/2/11 at 9:42 a.m., the following was observed: a. A vial of Lantus insulin for Resident #151 was delivered to the facility on 8/11/11. The vial of insulin was not dated when opened. b. A vial of Lantus insulin for Resident #154 was delivered to the facility on 8/27/11. The vial of insulin was not dated when opened		**dated when opened. DNS will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.** POC date: 10/6/11	

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	c. Two vials of Novolog insulin for Resident #52 were observed in the medication cart. One vial was delivered to the facility on 8/7/11 and the other vial was delivered on 8/13/11. Both vials of insulin were not dated when opened. The facility policy titled "Medications with Special Expiration Date Requirements" was reviewed on 9/2/11 at 11:05 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated the date of opening should be documented on the container/vial. 3.1-25(j)			

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F0441 SS=D	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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure handwashing was completed after picking up an item off of the floor and after glove removal for 1 of 2	F0441	**F – 441** It is the practice of this facility to ensure the highest quality of care	10/06/2011

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	meals observed in the West Unit dining room and for 1 of 2 treatments observed. (Residents #20, #194, CNA #5 and the South Unit Manager) Findings include: 1. On 9/1/11 at 12:15 p.m., CNA #5 brought Resident #20 her lunch tray. The resident was seated in the West Unit Dining Room. The CNA proceeded to remove the resident's bread from the package, as she did so, the butter packet fell to the floor. The CNA picked the butter packet up off of the floor and then proceeded to butter the resident's bread. The CNA was touching the resident's bread at this time. The CNA did not wash her hands or use an alcohol based hand gel after picking the butter packet up off of the floor. Interview with the West Unit Manager on 9/6/11 at 3:30 p.m., indicated the CNA should have washed her hands or used hand gel after picking the butter packet up off of the floor.		is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Re-education was provided to C.N.A. #5 regarding proper hand washing. South Unit Manager is no longer employed with this facility.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Facility residents have the potential to be affected by this alleged deficient practice, therefore facility staff have been re-educated on proper hand washing technique.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All staff will be re-educated on proper hand washing technique.** To ensure the deficient practice does not recur, the monitoring	

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			system established is: **A Performance Improvement tool has been developed to monitor proper hand washing technique among facility staff. Nursing administration will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.** POC date: 10/6/11	
	2. On 9/2/11 at 10:30 a.m., Resident #194 was observed lying in bed. The South Unit Manager was performing a pressure ulcer treatment to the resident's wound located on her right ankle. The South Unit Manager had washed her hands with soap and water and then applied clean gloves to both of her hands. She then removed old dressing and placed it in the plastic bag. She removed her gloves and threw them away, at that time, she realized she had forgotten the wound cleanser. She then walked out of room and brought back in the wound cleanser. The Unit Manager did not wash her hands with soap and water or use alcohol hand gel before			

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	leaving the room to obtain the wound cleanser. Review of the current 8/31/11 Hand Hygiene/Handwashing policy provided by the MDS Coordinator indicated Handwashing is the single most important procedure for preventing the spread of infection. If soap and water are not available and hands are not visibly soiled and alcohol based hand rub may be used for routine decontamination of hands in clinical situations. Hand hygiene is to be performed after removal of medical/surgical or utility gloves. Interview with the South Unit Manager on 9/2/11 at 11:00 a.m., indicated that she was aware she walked out of the room to get the wound cleanser before washing her hands after removing her soiled gloves. She further indicated she should have washed her hands with soap and water or used alcohol gel before leaving the resident's room after she removed her gloves. 3.1-18(l)			

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F0463 SS=D	The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the resident's call system was operational and functioning for 1 of 40 call lights tested. (Room 104) Findings include: On 8/29/11 at 2:36 p.m., the resident in room 104 pushed the call light in her room to call for help. At that time, the call light did not light up at the Nurse's Station or above the outside of the resident's room. CNA #8 entered the room at that time and turned the call light on and it did not light up outside of door or at Nurse's Station. On 8/29/11 at 2:42 p.m., Maintenance Employee #1 entered the resident's room and checked the call light by pushing the red button on top of the call cord. The light did not come on outside of the room or at the call panel at the Nurses' Station. Interview with Maintenance Employee #1 at that time indicated the cord to the call light was not working so he	F0463	**F – 463** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **The call-light was immediately repaired for Room 104.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A facility wide audit of all resident rooms was completed to ensure call light system was operational and functioning. No further issues were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **All staff will be re-educated on**	10/06/2011

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	replaced the call cord. Interview with the Maintenance Supervisor on 9/6/11 at 11:00 a.m., indicated he was made aware the call cord was not functioning immediately when it happened. 3.1-19(u)(2)		**protocol for notifying maintenance in the event a resident's call system becomes non-operational or non-functioning.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed to monitor the call system for proper functioning. Angels will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.** POC date: 10/6/11	
F0465 SS=C	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the kitchen area was sanitary and functional related to chipped, broken, and missing floor and wall tiles, non-functioning floor drain, soiled and broken utility carts, broken baker's rack, broken drawers and soiled floor in 1 of 1 kitchens. This had the	F0465	**F – 465** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for	10/06/2011

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	potential to affect 126 residents who consumed food prepared in the facility's kitchen out of a total population of 131 residents. (The Main Kitchen) Findings include: During the kitchen tour on 9/6/11 at 9:50 a.m., the following was observed: A. The 3 drawers of the prep table were broken, the drawers could not easily be opened. All of the drawers were in need of repair. B. The baseboard in the dish room was noted to have 6 chipped and broken tiles. C. The wall tiles around the second entrance door was noted to have broken and chipped tiles on the bottom 3 feet of door entrance. D. The paint on the metal door on the first entrance was chipped and in need of repainting. E. There were broken tiles at the base of the door and the bottom 4 foot section of the door entrance to the dry food storage.		the residents found to have been affected by the deficient practice was: **The prep table drawers were fixed, the tiles throughout the kitchen were either grouted or replaced, the metal entrance door was re-painted, the floor behind the storage racks was deep cleaned, the floor drain was fixed, the utility cart was replaced, the other utility carts were deep cleaned, the garbage cans were replaced, and the baker's rack was replaced.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Rounds will be conducted in the kitchen and all other areas found will be cleaned, replaced or fixed.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Dietary staff will be re-educated on cleaning schedules and reporting broken items to maintenance through the work order process.**	

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	F. The area around the bottom 3 feet of the back door had missing, chipped and broken tiles. G. The tiles around the bottom 3 feet of the door to the dish room were noted to be broken and chipped. H. There were 3 baseboard tiles under the window that had no grout. I. The floor in the corner behind the storage racks was heavily soiled with food debris and was in need of deep cleaning, J. The floor drain that collected the walk-in refrigerator condensation was full of water. The water was above the drain and formed a puddle on the floor. The drain was functioning properly. K. There were missing wall tiles around the window by the 3 compartment sink. L. One of seven utility carts had a broken bottom shelf. M. Five of seven utility carts had heavily soiled wheels and were in need of deep cleaning. N. Two of three garbage cans had		To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed to monitor the kitchen for safe, functional, sanitary, and comfortable environment. ED or designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.** POC date: 10/6/11	

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	cracks or wheels that were broken. O. One of two baker's racks has missing and/or broken slats. Interview with the Registered Dietician at the time of the tour, indicated all of the above areas were in need of cleaning and/or repair. 3.1-19(f)			
F0520 SS=E	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and	F0520	**F – 520**	10/06/2011

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	interview, the facility failed to ensure to the approaches for a dental service identified through Quality Assurance were implemented related to resident's receiving Dental services for 2 of 3 residents reviewed for dental status of the 6 residents who met the criteria for dental status and services. (Residents #15 & #80) Findings include: The Quality Assessment and Assurance Task was conducted on 9/6/11 at 10:56 a.m. The facility Administrator was interviewed at this time related to the facility's Quality Assessment and Assurance team. The facility Administrator indicated concerns were identified approximately three or four months ago related to dental services. The Administrator indicated in preparation for their annual survey, residents were interviewed related to dental concerns and the Quality Assurance team noted the need to follow up based on the resident responses. The team noted the concerns of the residents related to mouth pain and not being addressed by the dentist. The immediate action was to place those residents on the list to be seen by the dentist service. The Administrator indicated Social Services was		It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **R15 refused dental services. R80 has been seen by the dentist.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **A full house audit related to timeliness of dental services will be conducted. All residents needing to be seen will be referred to the dentist.** *The measures put into place and systemic change made to ensure the deficient practice does not recur is:* **ED has been re-educated on the importance of ensuring on-going compliance with routine dental care for all facility residents with the PI meeting serving as the method**	

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	appointed to do a house-wide audit of all residents. The Administrator indicated she was informed everyone was reviewed. The Administrator indicated the Dental provider had been changed, and the facility will need to evaluate the identified dental area as new concerns identified during survey related to dental visits/services not provided for Residents #15 & #80. The survey team identified a concern related to two residents not being evaluated or treated by the Dentist in over a year. On 8/29/11 at 2:26 p.m., Resident #15 was observed in her room. Spaces were noted between her lower teeth. The resident's lower teeth appeared discolored. The record for Resident #15 was reviewed on 8/31/11 at 1:59 p.m. The resident was admitted to the facility on 12/4/2008. The resident's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure high blood pressure, and depressive disorder. Review of the 8/11 Physician Order Statement indicated there was an order written on 1/17/2011 which noted the resident could be seen by the dentist as needed. There were no		**of tracking. Dental services will be part of the PI agenda.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed to monitor for the timliness of dental service. Social Service or designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI Committee for review until 100% compliance has been met.** POC date: 10/6/11	

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	dental consults or dental visit reports in the resident's record. The record for resident #80 was reviewed on 8/31/11 at 8:48 a.m. The resident was admitted to the facility on 8/2/2008. The resident's diagnoses included, but were not limited to, osteoarthrosis, malignant neoplasm of the colon, dementia and depressive disorder. Review of a 3/11/10 Care Plan Conference Summary note indicated the resident needed a dental appointment. A consent to authorize (name of dental provider) was signed by the residents daughter on 3/11/2010. The consent gave authorization for the resident to be seen by the dentist/hygienist. When interviewed on 8/31/11 at 1:43 p.m., the west unit Social Service Director indicated resident had not been seen by the dentist since the 3/11/2010 care conference summary. The most recent dental visit consult was 4/30/09. The 4/30/09 consult indicated the resident was having pain in some root tips. There were no further dental visits available in the resident's record.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	09/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	3.1-52(b)(2)			